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**FINANCING HEALTH SERVICES
THROUGH INSURANCE:
A CASE STUDY FROM KENYA**

Submitted to:

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Office of Health
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By:

**Germano Mwabu
Joseph Wang'ombe
Gerishon Ikiara
Mutsembi Manundu
Dr. Simon Kiugu**

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HEALTH FINANCING AND SUSTAINABILITY PROJECT

**Abt Associates Inc, Prime Contractor
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814 USA
Tel: (301) 913-0500 Fax: (301) 652-3916**

**Management Sciences for Health, Subcontractor
The Urban Institute, Subcontractor**

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**HEDRA LTD
Galaxon House, 6th Floor
Golf Course Commercial Center
Bagamoyo Road, off Mbagathi Road
P.O Box 19884, Nairobi, Kenya
Tel 254-2-718204, Telefax 254-2-718204**

ABSTRACT

Over a 20-year period of economic decline resulting primarily from uncontrolled expansion of the country's public sector and its deteriorating trade industry, Kenya's public health services have suffered significant shortages in drugs, personnel, and facility maintenance. One reform option for government medical service underfunding is the development of user fee-based health insurance. It is believed health insurance would protect households against financial risk in the event of their inability to afford health care. In Kenya, however, health insurance is a service burdened with serious limitations, both geographically (it is available primarily in the urban sectors) and in coverage provided. Kenya's current insurance system is weakened by internal and external problems, including fraudulent claims, outdated insurance laws, and the need for better regulation of insurance markets.

This report documents a survey undertaken in three Kenyan districts to determine the feasibility of developing private and public health insurance plans. A total of 153 employers, insurance companies, and health care providers were interviewed. Results confirmed that most employers already purchased some type of insurance for their employees, commonly workmen's compensation and group medical insurance. Employers, however, are generally dissatisfied with their current options and would be interested in more refined mechanisms.

Four promising insurance schemes have recently emerged: the national hospital insurance fund, Harambee movement funds, private insurance, and prepayment schemes. Development of some or all of these schemes and additional actions, such as revised tax laws that support insurance purchases by employers and households and basic insurance education for the public, are strongly supported as positive remedies for the current insurance problems in Kenya.

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ACRONYMS

AKI	Association of Kenya Insurers
AR	Applied Research
CBS	Central Bureau of Statistics
HFS	Health Financing and Sustainability Project
KHCFP	Kenya Health Care Financing Project
NGOs	Non-Government Organizations
NHIF	National Hospital Insurance Fund
NSSF	National Social Security Fund
SAR	Small Applied Research

FOREWORD

The Health Financing and Sustainability (HFS) Project provides technical assistance and conducts applied research, training, and information dissemination to developing countries in health economics, health sector policy development, and health services management. The applied research (AR) component of the project provides opportunities to increase knowledge of the complex issues underlying health financing problems, and augments the supply of qualified individuals who can contribute to policy analysis and reform. HFS is emphasizing the following policy areas for AR activities: cost recovery, productive efficiency, social financing, and private sector development in the health sector.

As part of the project's AR component, HFS will complete up to 30 small applied research (SAR) activities over the life of the project, from 1989 through 1994. These include studies undertaken by developing country researchers, HFS researchers, or academics at universities in the United States. The objectives of the SAR program are to carry out practically oriented research in developing countries, and to encourage the development of local capacities to undertake research.

Most SAR activities are initiated through proposals to the HFS Project. The proposals are evaluated by HFS staff, including criteria such as: practical policy orientation, resource and time requirements, and appropriateness to the HFS research agenda. Most proposals for SAR activities accepted by HFS undergo several revisions, as the researchers refine their research objectives, hypotheses, and methodologies, based on suggestions and comments from the HFS staff. Once approved, SAR activities are overseen by HFS task managers, who work closely with principal investigators to monitor the timeliness and quality of the work and facilitate logistics.

Other SAR studies are done in conjunction with technical assistance or major applied research activities of the HFS Project. In these cases, the SAR contributes to the technical guidance provided to clients, or adds to the body of knowledge of topics of health financing and economics.

As with all HFS research, drafts of SAR reports are reviewed by HFS staff. Drafts are then evaluated by external technical reviewers selected on the basis of substantive and/or geographic expertise.

Holly Wong
Applied Research Coordinator

PREFACE

In response to a persistent financial crisis in the health sector, the Kenya Government gradually shifted from the old method of financing health services through general taxation to a new system of user charges in public health facilities. Implementation of the new system started in 1988 and was concluded during the first quarter of 1993. Under the new system, health insurance has assumed prominence as a possible mechanism for cushioning households against risk of financial ruin in the event of catastrophic illnesses or inability to afford medical care.

This study examines the potential for developing private and public health insurance schemes in Kenya. Detailed data sets from 153 establishments (111 employers, 23 insurance companies, and 19 health care providers) in three urban areas show that there exists potential for developing health insurance both for people engaged in modern sector activities as well as for those employed in the informal and agricultural sectors. The research further shows that virtually all employers purchase some type of health insurance for their workers, the most common insurance schemes being workmen's compensation schemes and group medical benefits. Employers appear to be unsatisfied with these schemes, however, because in addition to the schemes, they also make other medical care arrangements for their employees. These include provision of medical facilities at workplaces as well as medical schemes negotiated directly with providers, without involving insurance carriers.

Changes in corporate taxes that encourage purchase of insurance by employers and individuals, amendment of insurance law to remove its undesirable aspects, and increasing the sources of public information about insurance seem to be the most promising ways of promoting growth of the health insurance industry in Kenya.

EXECUTIVE SUMMARY

INTRODUCTION

Over the past two decades, the Government of Kenya managed to allocate only about five to seven percent of the national budget to the financing of medical care. This has resulted in a major underfunding of this essential service.

Development of health insurance schemes is one of the reform options that is being explored in an effort to cope with the problem of severe budgetary constraints in health services delivery. Private health insurance in Kenya is limited, and is mainly an urban phenomenon. For example, of 38 companies in the country, only five companies underwrite health or medical insurance schemes. Moreover, medical insurance schemes are underdeveloped in terms of their coverage and the content of the services they deliver. However, several examples of promising insurance schemes emerged in post-independent Kenya. These include the national hospital insurance fund, Harambee movement funds, private insurance funds, and rural-based prepayment schemes.

RESEARCH QUESTIONS AND METHODOLOGY

This study attempted to answer the following empirical and policy questions.

- ▲ Against what types of illness expenses do Kenyans generally insure themselves? How do these differ across social groups?
- ▲ What kinds of insurance market structures exist in urban and rural areas in Kenya? How do these structures affect geographical and social distribution of health insurance services?
- ▲ What policy instruments need to be designed to promote the development of the insurance industry in Kenya? What further policies need to be pursued to ensure equity in health insurance coverage in the population? Are there incentives that the government can give to encourage the expansion of the insurance industry?

In an endeavor to conduct an empirical analysis of these questions, a variety of survey instruments were used to collect data on: types of insurance in the country; public policy on insurance, especially health insurance; structure of rural and urban insurance markets; and types of health insurance coverage commonly purchased by the population.

The survey was carried out between December 1992 and May 1993 in Nairobi, Nyeri, and Machakos districts. Nairobi, with about two million people, is the country's administrative and industrial capital. Most of the insurance firms in Kenya are situated in Nairobi. Nyeri is a small town of about 100,000 people and serves a largely rural population of central Kenya. It is situated about 150 kilometers north of Nairobi. The town was chosen for the study mainly because it

serves as a hinterland inhabited by a very large rural population—a key concern in our study.

Machakos is the largest town in eastern Kenya, with a population of about 80,000 people. It is situated some 40 kilometers southeast of Nairobi. Machakos was chosen because it is a peri-urban area—in relation both to Nairobi and Nyeri, i.e., the short distance between Machakos and Nairobi makes it a medium-sized town, half-way between a metropolitan city like Nairobi and a rural town like Nyeri. It serves as a satellite town to Nairobi. Due to its proximity to Nairobi, Machakos serves a large urban and rural population.

The target sample for the study was 254 establishments. Contrary to plans, however, the following sample sizes were realized: employers (111), insurance firms (23), and health care providers (19). Thus we ended up with a sample size of 153 establishments. Reasons for the high sample attrition are given in the main text.

We analyzed the health insurance situation in Kenya from the perspective of a competitive market model. This model is to be viewed merely as a benchmark analytic construct. It helps uncover shortcomings in health insurance markets, and how these defects can be rectified by public policy.

FINDINGS AND POLICY IMPLICATIONS

At the time of the study, there were 38 registered insurance companies in Kenya. Twenty-three of these responded to our questionnaires. One common business feature among the companies is that each of the companies underwrites several different kinds of risk. The most common insurance business portfolios for the insurance companies are marine, motor vehicle, life, public liability, personal accidents, and fire risks.

Only five out of the 23 insurance companies in our sample sold medical insurance schemes as pure insurance packages. Among the remaining companies, those that underwrite medical expense risks normally package them together with other insurance coverage or require that the insurees hold other insurance schemes with them. Other such schemes involve coverage for accidents, death, and disability compensation, workmen's compensation, and group medical schemes for out-patient and in-patient treatments. We find that the private health insurance market in Kenya is oligopolistic, but contestable. One reason for this latter attribute is that insurance companies do not sell insurance policies directly; they use brokers and agents. There are about 3,000 insurance brokers and agents in Kenya. The agents and brokers introduce a strong competitive element in the insurance industry. The spread of health insurance (both private and public) has been uneven and slow. There is potential, however, for extending modern insurance coverage to people working in the informal, unregistered establishments. The National Hospital Insurance Fund, despite its weaknesses, is perceived to have a major role to play in the financing of medical care in the country.

The study has suggested several policy options which need more work to concretize intervention designs. The results of our study suggest that:

- ▲ The pervasive aversion to risk taking in health insurance by the insurance companies can be moderated by better information flow between all the actors in the insurance market;
- ▲ Cost escalation can be controlled by judicious regulation of health insurance markets;
- ▲ Fraudulence and mismanagement in the insurance industry discourage potential insurance buyers and investors and should be addressed with urgency;
- ▲ Fundamental changes are needed in the National Insurance Fund;
- ▲ Insurance law needs to be changed to enable the insurance industry to function better, and
- ▲ Potential exists for extending health insurance schemes in unregistered firms in urban areas and in non-market settings in rural areas.

1.0 INTRODUCTION

1.1 THE PROBLEM

During the past two decades, sub-Saharan Africa experienced the most relentless economic decline in the world. Over this period, the African region recorded an average growth rate of minus one percent (World Bank, 1993). This decline can partly be explained by a persistently high population growth rate, which eroded the region's capital formation ability; uncontrolled expansion in the public sector, which compromised efficiency in resource use; and a severe deterioration in terms of trade for primary commodities.

It is no surprise that in this situation of economic decline, increased demand for public health services has made it increasingly difficult for the large majority of African governments to afford costs of basic inputs required in the health sector. Thus, shortages in drugs and personnel and inadequate plant maintenance have become pervasive in the public health facilities in nearly all African countries. In addition to the financial difficulty, there are also severe allocative inefficiencies and other types of resource mismanagement. In the government sector for example, scarce public money has repeatedly been spent on ineffective interventions. In virtually all African countries, there have been an over emphasis of clinical medicine at the expense of preventive medicine. Confounding these allocative and operational inefficiencies are ineffective administrative and bureaucratic practices. Money is, for example, routinely wasted on brand-name pharmaceutical instead of generic drugs; health workers are wrongly deployed and supervised; there are poor drug prescriptions; and much of the health infrastructure is underutilized.

A separate but equally difficult problem is the glaring inequality in the consumption and distribution of health services in much of Africa. The urban poor and rural populations, for instance, have little access to basic health care, and receive low quality care. The bulk of available public financial resources is spent in secondary and tertiary health care facilities, which by design are urban-based and not easily accessible to the majority of the population.

As already noted, underfinancing of the public health care sector is widespread in sub-Saharan Africa. It is no longer in question that governments in sub-Saharan Africa cannot finance health care to the required level—in terms of acceptable quality and volume. Government financing of health care delivery in this region is inadequate, and there are no prospects for improving it in the short run (World Bank, 1987 and 1993). In the face of increasing demand for publicly provided health care, Kenya, like most other African countries, has over the last decade allocated only between five to seven percent of the national budget to the financing of health care. This has resulted in a major underfunding of this essential service.

Available evidence, especially in Kenya, shows that quality of care has declined over the years: general accessibility of health services has sharply declined, problem of shortages of drugs and medical commodities has become

perennial, and facilities of the national referral hospital are in very poor condition (Republic of Kenya, 1988; Makinen, 1988). These problems have raised the urgency to search for additional financing strategies to supplement public resources in the health sector.

1.2 HEALTH CARE FINANCING POLICY REFORMS

Recent studies on health finance (USAID, 1988 and 1989; World Bank, 1993) have proposed several reforms to improve the financing and management of health care delivery systems in Kenya and elsewhere in the developing world.

These proposals, some of which have already been implemented, include:

- ▲ Charging users of public health services;
- ▲ Expanding the role of the private sector in the provision and financing of health services;
- ▲ Decentralization of government health services and strengthening of district health systems, and
- ▲ Tapping other sources of finance (especially budgetary reallocations) and improving efficiency in the public health sector.

In implementing some of these proposals, the Government of Kenya (with a grant from the USAID) developed the Kenya Health Care Financing Project (KHCFP) to provide technical assistance to the Ministry of Health in its search for options to broaden its financing base. Technical assistance is needed to deal with issues of intervention design, implementation, and sustainability. Introduction or development of health insurance schemes is one of the health care financing options that is being explored by KHCFP. Strengthening of health insurance in the country is expected to encourage expansion of the private sector and enhance the financial resources for the public sector. This study analyzes the health insurance industry in Kenya and provides baseline information on which policy and future plans for the expansion and further development of this industry can be based. The study also provides rich descriptive information about the insurance industry in Kenya.

At the global level, USAID has sponsored a project to provide technical assistance on the issues of sustainability of health care financing reform initiatives to several countries. This project works in collaboration with local initiatives on health care financing. This study fits in two categories of the global Health Financing and Sustainability Project (HFS) currently being undertaken by Abt Associates Inc., namely, the social financing and private sector categories. The study examines the possibilities of enhancing the role of various groups in Kenya, especially employers and consumers, in the financing of health care, so as to reduce their over-reliance on government in this respect. The study falls within the private sector category of the global HFS research agenda, since it examines insurance schemes primarily in the private sector and, to a lesser extent, in the parastatal subsector. Considerable emphasis is given

to an examination of factors which have helped or hindered the development of private sector-based health insurance schemes in the country so far, and how these factors could be manipulated to promote this mode of health care financing in the coming decades.

1.3 HEALTH INSURANCE

In countries where markets for health services function relatively well, private insurance is an important mechanism for financing medical care. In countries where health care markets are underdeveloped (or are not allowed to form), however, various types of social insurance schemes are the principal mechanisms of paying for health services delivered to the general population. Health insurance is an institutional and financial mechanism that helps households, individuals, and organizations set aside financial resources to meet costs of medical care in the event of illness. Health insurance schemes and related forms of social financing have become important mechanisms for complementing the health finance available from public sources in some developing countries, especially in Latin America (Abel-Smith, 1989). Health insurance, however, is only beginning to take root in sub-Saharan Africa.

An individual, household, or organization needs health insurance to cover itself against two basic types of risks, namely:

- ▲ Losses due to cost of normal but expensive illnesses. Households and other agents typically like to cover themselves against expenses which are likely to occur due to some illness in the future. If the sum of premiums these agents have to pay to join a risk-sharing scheme is smaller than the expected cost of illness, then the risk-sharing scheme is worthwhile and they are likely to join it.
- ▲ Costs of catastrophic and unexpected illnesses. Certain illnesses will occur within a population which will involve the affected household in major financial outlays on medical care. Individual households, however, face a very small probability of experiencing such catastrophic illnesses. For an affordable premium, each household would like to be covered against such expenses. Both the poor and the rich need insurance to cover themselves against these risks.

The attractiveness of health insurance lies in risk sharing. Health insurance involves sharing illness costs between the well and the sick. At any one time, it is only a part of the insured population that will need to claim for benefits from the insurance scheme. At the same time, all the insured will pay their premiums regularly. Hence, at the time of medical treatment, the cost of the insurance the individual pays (i.e., premiums) will be lower than the cost of illness for which the insurer pays. The insurer will be able to pay the benefits of the insurance scheme and at the same time make a profit. To the suppliers of health care, insurance is attractive because it provides a guarantee that the services will at least be paid for at cost. In this sense, insurance insulates providers from business losses.

There are three conditions that must prevail for private market insurance to thrive:

- ▲ Providers of health services must charge for their services. Insurance will not thrive in situations of free services. In such situations, households would have no incentive to buy insurance coverage because they would face no financial risk from illnesses.
- ▲ The insured population must be able to maintain regular payments of insurance premiums. Regular payment of premiums guarantees that whatever scheme is in operation is adequately financed. Otherwise, insurers and medical care providers will not be able to operate since there would be no funds to meet their costs.
- ▲ The legal and administrative framework must be supportive of private insurance entrepreneurship. The government might need to enact enabling legislation specifically for such a purpose, if it does not already exist. Existing legislation may also need to be amended if it introduces entry barriers to the insurance market.

There are many types of insurance mechanisms in Kenya, spanning different varieties of social and private insurance schemes. What follows is a brief description of major insurance categories in the country. We start off with the formal social insurance schemes in the health sector. Social financing of health services includes those modes of health care financing that do not depend directly on the exchequer or corporate financing. It encompasses different types of risk sharing and prepayment schemes. Social financing of health care in Kenya is underdeveloped relative to the other modes of financing. As shown here, however, there are several conspicuous and illustrative examples of health insurance schemes in the post-independent Kenya.

1.3.1 National Hospital Insurance Fund (NHIF)

NHIF is a compulsory hospital insurance scheme for all employees earning upward of Ksh 1,000. It was established in 1966 and operated under the supervision of the Ministry of Health. Prior to 1991, all those eligible for the scheme paid a uniform monthly premium of Ksh 20 (approximately US \$0.30). Since 1991, several changes have been introduced in the NHIF. Premiums have been increased, and are based on salary levels. The lowest monthly premium is Ksh 30 (about US \$0.50), paid at the entry salary of Ksh 1,000 (approx. US \$20). The highest monthly premium is Ksh 320, paid by those earning upward of Ksh 15,000 per month. If a beneficiary of the NHIF is hospitalized at a particular health facility, the NHIF compensates that facility at a fixed daily rate, based on the type of facility, as categorized by the Ministry of Health. Health facility categories range from small nursing homes to large public and private hospitals. Cost compensation rates per hospitalization day per patient range between Ksh 80 and 450. The small facilities recover daily costs at the rate of Ksh 80, while the largest facilities recover daily costs at the rate of Ksh 450. Any expenses in excess of the daily rate allowed for any facility are paid for by the patient from other sources.

The NHIF is presently estimated to have a membership of over one million people. Assuming that the average size of the nuclear family in Kenya is six, NHIF covers about six million people or approximately 25 percent of the total population for part of their hospitalization expenses.

1.3.2 Harambee Movement Funds

The Harambee movement in post-independent Kenya generated substantial funds, especially in the 1970s and 1980s, to finance social services such as health and education. Harambee refers to the ad hoc community practice of voluntarily pooling together community resources to finance private as well as public projects. In the health sector, Harambee has been characterized by contributions for financing two types of expenses:

- ▲ **Infrastructural expenses:** Voluntary contributions have been used as for the construction of dispensaries and expansion of hospitals. Since the early 1980s, the Harambee movement has expanded hospital in-patient capacity by 144 hospital wards countrywide. The communities usually spend their money on capital investment in health infrastructure under the assumption that the government would take over the burden of recurrent costs once the facilities have been constructed. By pooling resources together through Harambee, many communities were able to bring health care facilities near their homes. This mode of community financing was highly attractive to various Kenyan communities, when government health services were provided free of charge.
- ▲ **Expenses for catastrophic illnesses:** Individuals contribute voluntarily to a common fund for bailing out families faced with heavy medical bills. The incentive for an individual family to contribute to such a fund on a voluntary basis, rests on the expectation that if it were to be struck by a misfortune of a catastrophic illness, other families would bail it out. A family typically tries to avoid the risk of being bankrupted by such an illness by entering cooperative risk-sharing arrangements with other families. This type of insurance mechanism, informal as it is, is very common among Kenyan families in rural and urban areas.

1.3.3 Private Insurance Funds

The private health insurance industry in Kenya is an urban phenomenon. Historically (before independence), health insurance services were provided only to non-Africans in urban areas where high-quality health services were available on a fee-for-service basis, mainly in the private sector. As a result of this, a small health insurance industry began to thrive in urban areas. This is because when people are able to participate in private medical care markets, they almost always do so, naturally wanting to cover themselves against costs of catastrophic illnesses. It should be noted that user fees are a necessary but not sufficient condition for the development of health insurance markets. Prior to 1967, for

example, user fees were charged for health services in Kenya, but health insurance markets did not develop outside the urban areas. Between 1967 and 1989, the government provided free health services. During that period, the majority of the population did not need to consider private health insurance as a serious mechanism for paying for medical care. This situation changed in 1989, however, when the government instituted a system of user charges in government health facilities. The system is still in place, after a temporary suspension in 1990.

Existing private health insurance in Kenya can be grouped into two categories.

- ▲ *Direct private health insurance:* This type of insurance is acquired directly by the individual or the household. It is typically confined to the people in middle- and high-income groups;
- ▲ *Employment-based insurance:* There are two types of employment-based insurance (in addition to NHIF, which is compulsory for those who are eligible): workmen's compensation and group health insurance. Workmen's compensation is statutory insurance coverage bought for all employees by employers. It only covers employees for injuries sustained at the place of work. Workmen's compensation does not cover the worker for costs of other kinds of health problems or medical care for dependents, and
- ▲ *Group health insurance is more general.* Some government parastatals and private companies buy this type of insurance for their employees. Often, the type and extent of coverage is negotiated between insurer and employer. Many of the policies in this category operate on a reimbursement basis. That is, the insured workers are reimbursed the expenses they incur on medical care. It is estimated that group health insurance covers about 100,000 people in Kenya (Abel-Smith, 1989).

1.3.4 Rural-Based Prepayment Schemes

Rural-based prepayment schemes are a recent phenomenon in Kenya. They appear, however, to provide a mode of financing health care for the rural population that is promising and has great potential for expansion. The few examples that can be cited are based on rural cooperatives and community groups. For more than five years now, Chogoria Hospital in Tharaka-Nithi District has made arrangements with the local coffee cooperative society so that its members can receive medical care on credit. The money owed to the hospital by the cooperative society members is recovered from their coffee cooperative societies. The disadvantage, however, is that the scheme covers only those who are members of the coffee cooperative movement in the district (Kirigia, 1987).

Other examples of prepayment schemes include the experiments based on the Bamako Initiative (UNICEF, 1990). These experiments have so far been started in eight localities in Kenya. The participating communities start revolving drug funds with assistance from UNICEF. The community pharmacy, which was started

with this assistance, is stocked with generic drugs from the essential drugs list. Prices for these drugs are modest. Members of the community pay for drugs directly to the pharmacy. The money goes into the revolving fund. Due to their moderateness these prices are considered reasonable both by consumers and providers and do not, therefore, discourage use of drugs or their stocking. Consequently, it is hoped that the revolving drug fund will help community pharmacies maintain adequate stocks of essential drugs. The other sources of drugs in the community are general retail shops and private pharmacies. Private pharmacies are concentrated in big urban centers, however, which are hardly accessible to rural communities.

1.4 RESEARCH QUESTIONS

Health insurance is an essential mechanism of paying for health services in a situation where provision of these services is privately financed. The need for health insurance in Kenya has been recognized by policymakers for quite some time now, as exemplified by the establishment of NHIF in 1966 through an Act of Parliament (Kenyatta National Hospital, 1988). This recognition raises several pertinent issues. First, why have the existing insurance schemes not been expanded to significantly cover rural populations and those urban residents who derive their livelihood primarily from the informal sector? Second, what policies need to be instituted to promote health insurance coverage across all social groups? This is a crucial matter because reforms to provide medical services in the public sector in accordance with market principles are now well under way. This study attempts to tackle these issues by providing information on the following empirical and contextual questions:

- ▲ Against what types of illness-expenses do Kenyans generally insure themselves? How do these differ across social groups?
- ▲ What kinds of insurance markets (in terms of structure, performance, and conduct) exist in urban and rural areas in Kenya? How do these affect the spatial and social distribution of health insurance services?
- ▲ What policy instruments need to be put in place to promote development of the insurance industry in Kenya? What further policies need to be pursued to ensure equity in health insurance coverage in the population? Are there incentives that the government can institute to encourage expansion of the insurance industry in the health sector?

2.0 DATA AND METHODOLOGY

2.1 DATA NEEDS

To conduct an empirical analysis of the research issues set out in Section 1.0, the following data were required: types of insurance in the country, including their principal characteristics; public policy on insurance, especially health insurance; structure and performance of rural and urban insurance markets; and types of health insurance coverage commonly purchased by the population.

2.2 DATA SOURCES

Data for this study were collected over a six-month period from four sources, all of which are related to the insurance industry:

- ▲ *Insurance companies*, both those selling general insurance and those specializing in health insurance;
- ▲ *Employers*, both those who bought group health insurance for their workers as well as those with workmen's compensation insurance;
- ▲ *Health care providers*, primarily those providers whose services were paid for through an insurance scheme, and
- ▲ *The Commissioner of Insurance*, the government official agency in charge of policies that regulate the conduct and performance of the insurance industry in the country.

2.3 STUDY AREAS

The survey was carried out between December 1992 and May 1993 in Nairobi, Nyeri, and Machakos districts. Nairobi, with about two million people, is the country's administrative and industrial capital. Most of the insurance firms in Kenya are situated in Nairobi. Nyeri, a small town of about 100,000 people, serves a largely rural population of central Kenya. It is situated about 150 kilometers north of Nairobi. The town was chosen for the study mainly because it serves a hinterland inhabited by a very large rural population—a key concern in our study. The principal occupations of people in central Kenya are small-scale commercial farming of coffee, tea and food crops such as maize, beans and fruits.

Machakos is the largest town in eastern Kenya, with a population of about 80,000 people. It is situated some 40 kilometers southeast of Nairobi. There is a variety of light industries in this town. Machakos town was chosen because it is a peri-urban area in relation both to Nairobi and Nyeri; that is, it is neither a metropolitan city, nor a small town. The short distance between

Machakos and Nairobi makes it peri-urban, in comparison with Nairobi, but it is not as rural as the town of Nyeri. Machakos serves as a satellite town for Nairobi. Due to its proximity to Nairobi, it services a large urban and rural population. The Machakos study site provides an opportunity to compare empirical results from a peri-urban area with those from a largely rural (Nyeri) and an urban (Nairobi) area. This comparison is important because it can provide a basis for formulating policies that would make health insurance services more accessible to the people who reside in urban, as well as in rural and peri-urban areas. As already noted, most health insurance services at the moment are concentrated in the capital city.

2.4 FIELD-WORK DESIGN

The field research focused on four units of analysis: 1) insurance firms (both those selling general insurance as well as those selling health insurance); 2) private health care providers; 3) employers in the formal sector, and 4) the Commissioner of Insurance. These units (except for the Commissioner of Insurance) were further categorized into smaller units of analysis. In the employer category, we drew samples from medium and large firms (those employing at least 20 people) for study. Within this category of firms, we created the following observational units: manufacturing companies, agro-based industries, transport firms, restaurants, banking, insurance, and health care providers. Within the category of health care providers, we restricted the data collection activity to hospitals, health centers, nursing homes, and maternity homes. The banking subsector was classified into commercial banks, financial institutions and finance houses. Thus, the sample of firms (employers) studied included the following:

- ▲ Manufacturing companies;
- ▲ Agro-based industries;
- ▲ Transport firms;
- ▲ Restaurants or catering firms;
- ▲ Commercial banks;
- ▲ Financial institutions;
- ▲ Finance houses, and
- ▲ Coffee plantations.

Insurance firms were studied for the information on insurers only. Hospitals, health centers, and dispensaries were studied only as health care providers.

Manufacturing firms and agro-industries that were sampled for the survey were all situated in Nairobi. Also located in Nairobi were the insurance and banking firms. The sample of transport firms, restaurants, and health care providers, however, included establishments in rural, peri-urban, and urban areas. Coffee plantations were surveyed in Nyeri district.

The field-work design was such that information was collected from heads or managers of the selected establishments. In the event of their unavailability, the required information was collected from their deputies. All those interviewed

were responsible people in decision-making positions. They included company directors, managing directors, chief accountants, chief personnel officers, and hospital administrators.

2.5 SAMPLING STRATEGY

The sampling for the employers was based on a survey conducted by Kenya's Central Bureau of Statistics (CBS) in 1991 on industrial and non-industrial firms. A list of 1,328 industrial firms was compiled out of the information provided by the CBS. The survey provided rich, firm-level information that included the following: name of the firm, its principal activity, location, and address. In terms of the three study areas, there were 1,300 firms in Nairobi, 20 in Nyeri, and eight in Machakos. Stratified and systematic random sampling methods were used to select 146 employers for interviews.

These sampling procedures and the same justification for the sample size were used to select additional 40 firms from the banking industry. All 38 registered insurance companies were included in the sample and 30 private sector health care providers were selected. The size of the overall expected sample was 254 establishments.

2.5.1 Sample Implementation

Sample implementation was not without problems, however. A number of sampled firms adamantly refused to participate in the study, citing time wastage involved in completing the questionnaires. This behavior forced the interviewing team to abandon the refusing firms for the next firm in the sample list. Other firms refused to answer some of the questions, especially those that touched on salaries. They said that secrecy concerning some aspects of their operations was necessary to ensure protection from adverse publicity in the event of such information leaking to unauthorized persons. These concerns led to missing information on a considerable number of questionnaires. A significant amount of time was spent by the interviewing teams explaining the purpose of the study to the firms that were being interviewed. This led to non-completion of some of the questionnaires because the time allocated for interviews could not be extended. Further, some firms had shifted their locations by the time the interviewing teams started work and therefore could not be interviewed.

Other firms subjected the interviewing teams to unnecessary delay in returning the questionnaires they had filled out on their own (the firms had insisted that they do this and the interviewers obliged). Due to these problems, there was heavy attrition in original sample. Contrary to plans, the following sample size was realized: employers (111), insurance firms (23), and health care providers (19). The sample was distributed geographically in the manner shown in *Exhibit 2-1*.

EXHIBIT 2-1 DISTRIBUTION OF THE STUDY SAMPLE BY TYPE OF ESTABLISHMENT AND DISTRICT				
	Nairobi	Nyeri	Machakos	Total
Agriculture	4	3	—	7
Manufacturing	35	4	2	41
Services	47	9	6	62
Health Care Providers	12	5	2	19
Insurance	23	—	—	23
Informal	1	—	—	1
Total	122	21	10	153

2.6 ANALYTIC CONSIDERATIONS

In this subsection, we provide an analytic perspective (i.e., a conceptual paradigm) that guides the study, and that we later invoke in interpreting empirical results. We analyzed the health insurance setting in Kenya from the perspective of a standard competitive market model. This model is used as a benchmark analytic construct rather than as a true description of the insurance situation in Kenya. It helps uncover the shortcomings in the structure, conduct, and performance of health care insurance markets in Kenya, and how these problems can be rectified by public policy. We begin by noting the fundamental result of a competitive market. If a market is perfectly competitive, economic efficiency prevails both in the production and consumption of the good or service that is being traded in that market. Consumption and production in this benchmark market proceeds according to optimum rules of marginal costs and benefits. Departures from these rules (except in well-known cases) typically imply economic inefficiencies, which need correction by public policy.

Determination of competitiveness of a given health insurance market requires that conditions for a perfectly competitive market be inspected. The market characteristics to look for in carrying out this determination are:

- ▲ Number and type of health insurance providers;
- ▲ Number of potential customers for services of insurance providers;
- ▲ Type and volume information about insurance providers;

- ▲ Homogeneity or heterogeneity of service provided by insurers;
- ▲ Type and extent of government regulations, and
- ▲ Nature of price fixing.

Conditions that permit applications of free market principles in the provision and/or financing of goods or services rarely hold in insurance markets. Insurance markets, particularly in the health sector, are characterized by peculiar attributes that adversely affect their performance (Feldstein, 1983; Mwangi, 1992). The problem of asymmetry of information is one such peculiar attribute in this situation. It occurs when both the insurer and the insured have incomplete (or do not share the same) information on nature and extent of risk(s) to be covered and the amount and packaging of benefits. Due to this problem, for example, insurers take precautions so as not to fall into the "adverse selection" trap. This precautionary behavior is detrimental because it excludes from insurance markets people who would otherwise have been insured. Adverse selection occurs when proportionately more people with high probability of making claims join insurance schemes and fewer people with low probability of making claims join them. When this occurs, the insurer eventually incurs losses because claims exceed the revenue that the insurer receives from premium payments.

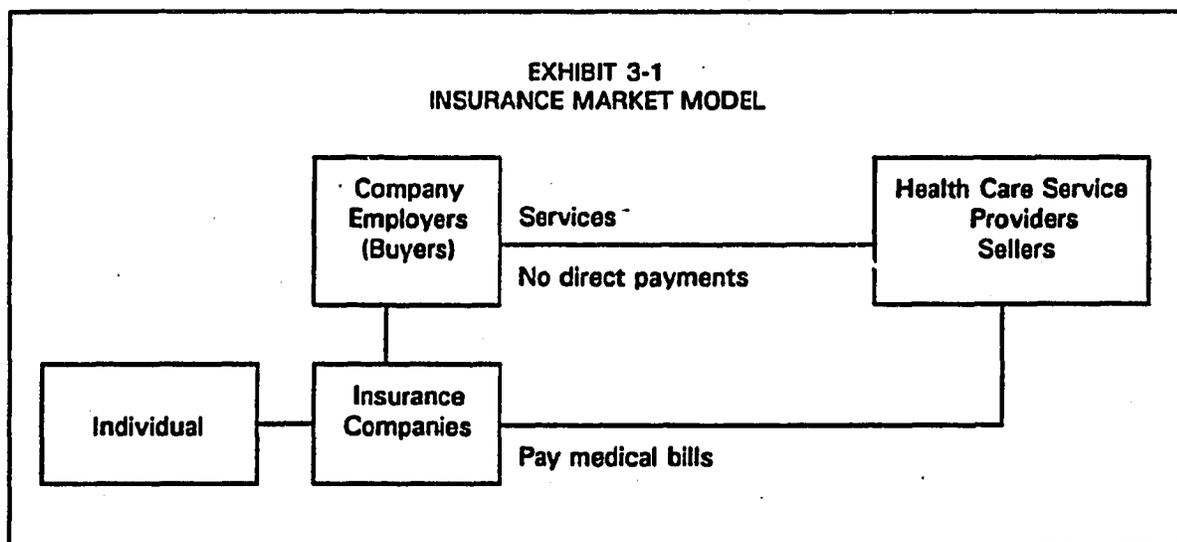
Performance of insurance markets also suffers from the well-known "moral hazard problem," which occurs when consumers use services unnecessarily, simply because they are insured. These problems, among others, lead to inefficiencies in health insurance markets, especially in low-income countries. These theoretical perspectives are used to interpret the empirical results presented in Section 3.0.

3.0 MARKETS FOR INSURANCE AND HEALTH CARE SERVICES

3.1 INTRODUCTION

This chapter gives an overview of the insurance market in Kenya. Each actor in the market is reviewed separately before describing the market context in which all actors are active participants.

The health insurance market we describe conforms to a well-known insurance systems model shown in *Exhibit 3-1*. The model comprises three groups of actors in a medical care provision process where there is no direct payment for medical care. The first group in the diagram is made up of health care providers who are essentially the sellers of health services. The second group consists of employers and individual households who need to buy medical care for their employees and members, respectively. This group pays for medical care through a third party, which consists of insurance companies. Employers and individual households buy insurance from medical insurance companies, who in turn pay for the medical cost claims made on employers and households by the health care providers.



3.2 OVERALL INSURANCE INDUSTRY

To begin with, notice that the health insurance system in *Exhibit 3-1* connects two markets: health services and insurance coverage. However, the market for health insurance is a portion of a larger market for different kinds of insurance services. The supply side of the insurance market is maintained by insurance sellers and the packages of insurance services that they sell.

At the time of the study, there were 38 registered insurance companies in Kenya. Twenty-three of these responded to our questionnaires, although, as noted

earlier, not all questions were answered. One common business feature among the companies is that each of the companies underwrites several different kinds of risks. *Exhibit 3-2* shows different types of insurance businesses and the number of companies that are underwriting each kind of risk. *Exhibit 3-3* shows common insurance services in Nairobi for individual households (Mwangi, 1992). This exhibit helps place our health insurance study in the context of the overall insurance industry in Kenya. Notice that Mwangi uses a slightly different categorization of insurance businesses than the one used in this report. Within Mwangi's categories, health insurance is provided through life, personal accident, and all risk insurance schemes. Households seem to purchase life insurance schemes more often than other forms of insurance (Mwangi, 1992). In contrast to what we learn from households, the most common insurance packages for corporations or businesses are marine, motor vehicle, life, public liability, personal accident, and fire insurance (see also *Appendix A*).

EXHIBIT 3-2 TYPES OF POLICIES, ANNUAL PREMIUMS, AND NUMBER OF COMPANIES UNDERWRITING THE INSURANCE			
Type of Policies	Number of Policies	Total Annual Premiums (Ksh)*	Number of Companies Writing the Insurance (n = 23)
Marine Insurance	1,466	215,679,014	13
Motor vehicle	13,716	622,080,297	16
Life Insurance	2,866	241,339,000	08
Pensions	81	358,000,000	04
General/Miscellaneous Insurance	5,501	306,571,956	11
Public Liability	1,599	94,582,121	14
Individual Personal Accident	716	204,784,375	07
Health Insurance	148	2,000,000	02
Group Medical Scheme Insurance	1,467	187,507,688	03
Fire Insurance	7,005	450,913,920	11

* US \$1 was approximately Ksh.70 at the time of the survey.

Premium rates in the insurance industry are determined by the individual companies. Only rarely do companies consult the Association of Kenya Insurers (AKI) before they determine premium rates. In the event that a company consults AKI, it may have access to information on the whole market because all the

companies are members of AKI. For example, AKI will know what premiums different companies are charging for different types of policies.

During the interviews, the insurance companies were asked to state what proportions of their clients lived in urban and rural areas. The analysis of this question showed that the clients of the insurance industry are predominantly urban (78 percent). Moreover, 80 percent of insurance agents operate in the urban areas.

3.3 HEALTH INSURANCE INDUSTRY

Health insurance is a very an unpopular business portfolio with insurance companies. Only five of the 38 insurance companies sell medical insurance schemes as pure insurance packages. Many insurance companies underwriting medical risks normally package them together with other insurance coverage, or require the employers or employees to hold other insurance schemes with them. These other schemes include group

accident, death and disability, workmen's compensation, and group medical insurance coverage. *Exhibit 3-4* shows the number of employers that participate in different schemes for different companies. It is clear that most health insurance coverage for people in employment occurs under these other schemes, but not through direct health insurance. From *Exhibit 3-5*, it would appear that for many employers, workmen's compensation (44) and group medical (20) schemes cover their employees for a wide range of specific medical expenses, namely, hospitalization, out-patient care, surgery, medication, consultation, laboratory, x-ray, loss of limbs, and death. Other employers select some specific medical expenses within this range, against which they buy insurance coverage for their workers under different schemes. It is common to find a company with more than one insurance scheme. For example, no company covers its employees for death or loss of limbs under the individual medical scheme, but such coverage may occur under workmen's compensation or a group medical scheme.

Health insurance schemes are organized such that benefits can be drawn by an individual, an individual and spouse, or an individual and nuclear family, and by groups, corporations, or associations. *Exhibit 3-6* shows different categories of insurance beneficiaries within the Kenyan health insurance industry. The number of insurance companies that package benefits for each category are shown. It

EXHIBIT 3-3 COMMON INSURANCE PURCHASES BY HOUSEHOLDS IN NAIROBI		
Types of Insurance	Number of Respondents	Percent of Respondents
Life Insurance	38	23.90
Fire Insurance	11	6.92
Burglary Insurance	4	3.57
Personal Accident Insurance	9	5.66
All risks	6	3.77
Professional Indemnity	3	1.89
Cash-in-transit Insurance	2	1.26
Motor Vehicles Insurance	19	11.95
Others	5	3.14
TOTAL	159	100.00
<i>Source: Mwangi (1992), p.32</i>		

is clear that group insurance packages are the most common risk-sharing arrangements.

The health insurance market is dominated by five insurance companies, which share the direct health insurance business among themselves. Insurance companies were asked to estimate the market share of the leading five health insurance companies in Kenya's health insurance industry. These companies are listed below in order of importance, based on their share of the market as determined by other insurance companies:

1. Madison Insurance Company
2. American Life Insurance Company
3. Jubilee Insurance Company
4. Pan African Insurance Company
5. Kenya National Assurance Company

EXHIBIT 3-4 NUMBER OF EMPLOYERS AND HEALTH PROBLEMS COVERED. UNDER DIFFERENT SCHEMES.*					
Health Insurance Scheme	Workmen's Compensation n=75	Group Medical n=45	Individual Medical n=7	Group Accident Death & Disability n=30	Others** n=5
Health Problems					
Accidents	73	17	04	26	01
Normal Illness	06	28	03	01	01
Chronic	01	05	00	00	00
Condition	02	13	03	03	03
All Conditions					
<p>* n denotes the number of employers who indicated that they subscribe to the particular insurance scheme.</p> <p>**Others include personal life insurance, group life insurance and employer liability insurance</p>					

Premium rates for health insurance are determined in the same way as those for general insurance. The company determines the rate after observing the general market situation, but may consult other companies or the AKI before determining its rates. The health insurance market was assessed as oligopolistic by six insurance companies, while another six companies believed the industry is competitive. One of the reasons why this market, with only a few sellers, could be termed competitive is because the companies do not sell insurance policies directly, but through brokers and agents. The commissioner of insurance estimated that there are about 3,000 insurance brokers and agents at any one time in the country. Insurance agents and brokers introduce a strong competitive element in the insurance industry, thereby making insurance markets highly contestable.

**EXHIBIT 3-5
SPECIFIC MEDICAL COSTS AND THE NUMBER OF COMPANIES THAT UNDERWRITE THEM
UNDER THE DIFFERENT INSURANCE SCHEMES***

Health Insurance Scheme n = 72	Workmen's Compensation n = 45	Group Medical n = 7	Individual Medical n = 33	Group Accident Death and Disability	Other* n = 5
Benefits:					
Hospitalization	12	09	02	05	01
Out-patient	13	07	02	03	01
Surgery	13	11	02	04	01
Medication	15	11	02	04	01
Consultation	12	09	02	04	01
Laboratory	13	09	02	04	01
X-Rays	12	10	02	04	01
Loss of Limbs	26	09	00	16	01
Death	19	06	00	19	01
All the above	44	20	05	13	01
Other	00	00	00	00	03

* "n" denotes the number of employers who indicated that they subscribe to the particular insurance scheme.
 ** Others include personal life insurance, group life insurance, and employer liability insurance.

Contestability in the insurance industry can further be increased by deliberate government policy.

The growth of the health insurance sector has been very slow since independence. As has been demonstrated in the previous exhibits, coverage for medical care costs for the labor force in the formal sector has been attained mainly through group insurance policies. There seems to be potential for expanding coverage for this group of the population through a variety of group policies. Based on information available from six insurance companies, it is clear that during the 10 years between 1980 and 1991, group policies increased by more than 265 percent, from 123 policy packages to 450 (*Exhibit 3-7*). These figures do not only reflect growth in group insurance, but also an expansion of employment in the formal sector over the same period. Consistent with this is the finding that health insurance claims increased by 162 percent, from 450 claims in 1980 to 1,419 in 1991 (*Exhibit 3-8*). While the percentage growth seems spectacular, the number of claims per group per year still remains small (*Exhibit 3-6*). There does not seem to be an obvious explanation for the low level of claims. It appears that employers would like to keep the number of claims low to avoid increases in premiums. Employers might be discouraging their workers from making unnecessary claims so as to keep premiums down. This is plausible because

**EXHIBIT 3-6
DISTRIBUTION OF THE COMMON CATEGORIES OF POPULATION GROUPINGS FOR
PACKAGING HEALTH INSURANCE AND HEALTH-RELATED INSURANCE IN KENYA, n=17**

Category of Insureds (Individual and Other)	Number of Times Mentioned	Number of Companies Writing It	Proportions
Individual Separately	11	11	0.65
Individual and Spouse	11	11	0.65
Individual, Spouse, and Nuclear Family	10	09	0.53
Groups	12	13	0.77
Others, e.g., Corporations and Associations	03	03	0.18

most of the group insurance schemes are noncontributory, in the sense that employees do not contribute to the premium. It should also be noted that all the private schemes complement the compulsory NHIF.

3.4 HEALTH SERVICES INDUSTRY

The sample of health providers that provided data for this subsection came entirely from the private sector because health care services in the public sector facilities were not paid through insurance. After the recent introduction of user fees, however, there has been a policy change to enable public sector health facilities to be reimbursed for hospitalization expenses incurred to treat beneficiaries of the NHIF. Government facilities can request reimbursement at a predetermined rate from the NHIF. The NHIF is now a major source of health insurance revenue for both government and private sector facilities (Republic of Kenya, 1993).

Health facilities in the private sector are fewer than those in the public sector. In Nairobi alone, there are 30 private facilities (excluding individual medical practitioners' surgeries), compared to 95 public facilities run by the Ministry of Health and the Nairobi Municipality. The study sample comprises 12 hospitals, one health center, four nursing homes and two maternity homes.

Health insurance is used to pay for a wide range of medical care services. *Exhibit 3-9* shows the specific medical care services for which private sector facilities were compensated by insurance schemes.

Patients who are paying for medical care through insurance use hospitals proportionately more than all other facilities combined. Not only do hospitals collect more insurance revenue than the other smaller facilities, but hospital costs are higher for equivalent services (see also *Appendix B*). There are three

EXHIBIT 3-7
SUMMARY OF THE GROUP INSURANCE POLICIES SHOWING
INCREASES BETWEEN 1980 AND 1991
(Only six companies provided the historical information)

Year	Number of Groups (policies)	Number of people	Total Premium, Ksh *
1980	123	100,000	70,000,000
1981	130	105,000	72,000,000
1982	137	110,000	75,000,000
1983	150	117,000	79,000,000
1984	159	120,000	80,000,000
1985	172	130,040	83,000,000
1986	211	146,534	88,823,018
1987	201	150,250	91,564,550
1988	218	151,232	95,503,805
1989	223	180,746	99,233,411
1990	333	201,207	112,453,620
1991	450	221,855	123,386,624

* US \$1 was approximately Ksh. 70 at the time of survey

possible explanations for this apparently non-conventional health care-seeking behavior.

- ▲ The private hospitals are concentrated in the urban centers where there is also a higher population density relative to rural centers;
- ▲ Quality of care is perceived to be higher in the private hospitals. The insured prefer hospitals to the lower-level facilities, such as health centers or dispensaries (see Mwabu, 1989) for a description of demand patterns within a referral system, and
- ▲ Insurance reimbursement payments are higher for hospitals with lower out-of-pocket expenses for the patients.

Patients who used health insurance in our sample originated from among employers in the following proportions: private companies, 35.6 percent; private groups, e.g., professional associations, 5.0 percent; private, individual employers, 11.1 percent; parastatals, 10.3 percent; government, 9.8 percent;

nongovernmental organizations, 7.1 percent; others, 20.2 percent. The category "others" includes small businesses which are not registered with the government as companies or as private clubs. The results show that health insurance coverage is largely available for people in formal employment, especially in the private sector. As the last user category indicates, however, there is great potential for extending health insurance coverage to persons working in small, unregistered businesses. This is an encouraging and important finding.

3.5 GROUP USERS OF HEALTH INSURANCE SERVICES

Employers in the private sector comprise the largest number of buyers of health insurance packages. These employers have a strong preference for group medical schemes for their employees.

For this study, a stratified sample of 146 private sector employers was planned. A sample of 111 employers was actually realized. It consisted of seven agricultural firms, 41 manufacturing firms, 62 service sector firms, and one informal sector firm (the informal sector is not registered with the registrar of companies).

Data from employers enabled us to corroborate information from the insurers and health care providers. The medical care services for which employers draw benefits from health insurance have been discussed elsewhere in this paper (see *Exhibit 3-5*). The benefits are packaged within the common health insurance or non-health insurance schemes. Elements of these group insurance schemes include: workmen's compensation, group medical schemes, individual medical schemes, group accidental death and disability schemes, and pure medical insurance schemes. NHIF, however, is the most important workers insurance scheme for most employers (*Exhibit 3-10*).

Exhibit 3-10 shows that most employers combine other insurance with NHIF as the medical care provider is compensated for only part of the costs by the NHIF. It therefore becomes necessary for employers to buy other insurance coverage to raise the value of insurance entitlement for their employees. The presence of firms in columns 1 and 3 of *Exhibit 3-10*, when NHIF is compulsory, can be explained by the presentation of two facts. First, laxity in the inspection of

EXHIBIT 3-8 INCREASE IN HEALTH INSURANCE CLAIMS BETWEEN 1980 AND 1991		
Year	Number of Claims	Value of the Claims (Ksh)*
1980	540	22,000,000
1981	610	24,000,000
1982	620	280,000,000
1983	640	31,000,000
1984	660	34,000,000
1985	687	37,035,482
1986	705	39,172,578
1987	744	40,328,201
1988	826	43,138,236
1989	922	45,320,880
1990	1218	48,729,326
1991	1419	58,962,582

*US\$ 1 was approximately Ksh. 70 at the time of survey.

the private sector by the government. NHIF has an inspection division which enforces the collection and remittance of NHIF premiums, and any company subscribing to NHIF that is not doing so is in contravention of the law. Second, there are firms with workers earning less than Ksh 1,000 per month. This is the case in some low-class hotels, which, according to the law, should be subscribing to NHIF. To avoid confusion, it is in order to elaborate on the interpretation of *Exhibit 3-10*. Row one of the exhibit says that one firm in the agricultural sector did not have any insurance at all, five firms had NHIF and some other insurance scheme, and one firm in this sector was not covered by NHIF. The other rows are interpreted similarly.

Many employers do not rely entirely on formal health insurance schemes to pay for medical care costs for their employees. Employers have made other arrangements to pay for part or all of some of medical care costs for their workers. The most common practice is to directly reimburse medical expenses to the workers. Workers have to spend their own money first and then claim for refunds from the employer. This arrangement should be popular with employers because the requirement that a worker spend his or her money first acts as a disincentive to abuse the medical scheme. Many companies also sponsor their own health clinics for treating minor ailments among their workers (*Exhibit 3-11*).

EXHIBIT 3-9 SPECIFIC SERVICES PAID BY INSURANCE	
Service	Frequency
Hospitalization	11
Consultation	09
Drugs	11
Surgery	10
Out-patients	08
X-rays	08
Laboratory	10
Diagnostics	00

EXHIBIT 3-10 FREQUENCY DISTRIBUTION OF NHIF AND NON-NHIF HEALTH INSURANCE SCHEMES AMONG DIFFERENT TYPES OF EMPLOYERS			
Type of Employer	No Insurance Schemes	NHIF & Other Insurance	Other Insurance Without NHIF
Agriculture	1	5	1
Manufacturing	2	36	3
Services	2	54	6
Informal	-	1	-

**EXHIBIT 3-11
OTHER MEDICAL SCHEMES
(APART FROM NHIF & OTHER FORMAL INSURANCE)**

Other Medical Care Arrangements	Number of Firms	Percent
1. No other arrangement	38	34.2
2. Group Clinic	14	12.6
3. Company pays for medical care bills directly to selected facilities	6	5.4
4. Company reimburses employees after they spend their own funds	24	21.6
5. 2 & 3 (above)	15	13.5
6. 2 & 4 (above)	5	4.5
7. Others	9	8.1
Total	111	99.9

3.6 EMPLOYERS' QUALITATIVE EVALUATION OF THE INSURANCE

Employers experience problems as users of health insurance services. They hold both unfavorable and favorable opinions about insurance schemes and have suggestions on how to improve certain aspects of the schemes. Employers expressed their views about the shortcomings of health insurance markets and schemes as follows (see *Appendix D* for a full list).

- ▲ Insurance is very expensive because premiums are very high;
- ▲ Insurance claims take too long to process because of the bureaucracy followed during claims settlement;
- ▲ Compensation is not commensurate with the cost of medical services;
- ▲ Insurance companies sometimes dispute doctors' assessments of costs, especially if they suspect fraud;
- ▲ Restrictions on who is to be covered under the insurance mean that very few people qualify for insurance coverage, and
- ▲ Existence of faked claims has generated extra scrutiny and suspicion on the genuine claims by insurance carriers.

Nonetheless, employers supported potential and actual usefulness of insurance schemes. They emphasized that insurance cushions them against excessive

medical care costs incurred by their workers. It enables poor workers who otherwise would have suffered under the burden of heavy medical bills to have quality care in a convenient manner. They made general proposals as to how health insurance services and markets can be improved. Some of the suggestions made were the following:

- ▲ Assessment of claims should be done early and fast enough to enable prompt payment;
- ▲ Employers and insurers should set and agree on general guidelines for compensation;
- ▲ The government should publish the true rate of inflation to enable insurers to charge premiums and benefits appropriately, and
- ▲ The government should sponsor and sustain a campaign to popularize insurance, by passing the correct information on the insurance industry to the population (see *Appendix E* for more suggestions).

To sum up, concerns of employers about the insurance industry fall into four categories: a) doubts about the health of the economy and its ability to support the expansion of the insurance industry; b) cost escalation in medical care, which appears to be associated with insurance schemes; c) mismanagement and operational inefficiencies in many insurance companies, and d) the inability of the government to effectively regulate the insurance industry.

3.7 NHIF STRENGTHS AND WEAKNESSES

This section looks at the NHIF in terms of information obtained from 89 employers who responded to NHIF-related questions. The rest of the information is from the few employers who were on other health insurance programs. Questions on NHIF focused on issues of its strengths and weaknesses and possible solutions to the identified weaknesses. NHIF's strengths are found in its effective cushioning of households against excessive medical care costs. NHIF also responds, to an extent, to the problem of equity in that it is a program that also covers people of low income. Concerns about weaknesses have to do with management and administration, cost escalation, and benefits determination and distribution. NHIF is also perceived to have a major role to play in social financing of medical care in Kenya.

Employers expressed their views about the strengths of NHIF (see *Appendix F* for details) as follows:

- ▲ NHIF pays a reasonable proportion of the hospitalization bill, hence relieving the members of the heavy financial burden;
- ▲ NHIF is prompt in making payments to hospitals and this induces hospitals to treat the beneficiaries of the NHIF well;

- ▲ NHIF is appropriate and beneficial to low-income earners who cannot afford other expensive medical insurance schemes;
- ▲ NHIF caters to health needs of the entire family, and
- ▲ Members of the NHIF can be admitted to any hospital they prefer so long as it is recognized by the NHIF regulations.

Employers also identified shortcomings in NHIF, which they expressed as follows (see *Appendix G* for details):

- ▲ Out-patient bills are not covered; the existing coverage for medical bills is not adequate;
- ▲ The reimbursement by NHIF is minimal;
- ▲ The bureaucratic procedures followed when claiming money from NHIF are cumbersome and wastes time;
- ▲ The premiums are high while benefits are quite limited, and
- ▲ The reimbursements are based on fixed rates for some hospitals, while for others the rebates are too low.

Suggestions as to how to improve NHIF as put forward by the employers are as follows (see *Appendix H* for details):

- ▲ NHIF should also cover the out-patient costs;
- ▲ Compensation should not be delayed;
- ▲ The NHIF should pay for the total hospitalization bill, and
- ▲ The services should be improved, e.g., by decentralizing administration of the NHIF.

There is an apparent contradiction between some of the stated strengths and shortcomings of the NHIF. Some employers indicated that NHIF offers adequate compensation while others stated the contrary. This is a reflection of the ongoing debate as to how to improve the NHIF. The mixed experiences that employers have had with the NHIF is an indication that NHIF treats employers (or users of its services) differently, but in an undesirable manner. This should not be so.

4.0 DISCUSSION AND POLICY ISSUES

4.1 INTRODUCTION

This chapter discusses the results of the study and presents preliminary policy options. The discussions begin with the structure and problems of expansion of the health insurance market. The role of the various actors in the market is highlighted. The last section of the chapter discusses policy questions based on the problems as identified by groups of key actors in the insurance industry.

4.2 HEALTH INSURANCE MARKET

In many respects, the health insurance market does not approximate a competitive market. The number of buyers in this market is large, but the sellers are relatively few. This observation becomes clear when the general insurance market is partitioned into health and nonhealth components. At any one time only 11 of the existing 38 insurance companies underwrite any risk that includes medical care costs. Further, only five companies have health insurance as an independent business portfolio. Barriers to the expansion of the health insurance market fall into the standard textbook problem categories for the insurance industry in any economy. What is important about them is their specificity in respect of the Kenyan economy. Consider, for example, the following aspects of the medical insurance market.

Adverse selection. The typical adverse selection problem is characterized by the aged and the chronically sick buying insurance, while the young and the healthy adults avoid it. In this category we also include the buyers with low incomes, and low levels of literacy. The insurers take precautions not to issue coverage to people who would have problems maintaining their premium accounts. If the insurers did not take this precaution, their insurance business would be unprofitable. In the case of Kenya, medical insurance companies try to avoid self-selectivity problem by selling insurance mainly to corporations, or associations of professionals, or high-income individuals. In fact, even the government sponsored insurance scheme, the NHIF, also follows this policy and targets its insurance sales to high-income individuals.

Moral hazard. Concerns with this problem include rising costs due to increased demand for medical care (for those with insurance) and consequently unnecessarily high-claim rates. Insurance companies assess the health insurance portfolio as a low-profit-business line because of the moral hazard phenomenon. In Kenya, excessively high-claim rates, especially at the NHIF, is a serious problem. This is one of the reasons why insurance companies were reported to be slow in settling medical expense claims submitted by health facilities or individuals.

Cost escalation. Premiums are rising due to increased medical bills, inflation, and fraudulent claims. Medical costs are also believed to be rising because they are paid for by insurance. Many employers felt that rising insurance

premiums are undermining their ability to buy insurance coverage for their employees.

Administrative burden. The respondents in our study felt that costs of administering the programs are rising because the process of determining the premiums is difficult; costs of services of assessors and actuaries are rising and documentation has become quite expensive.

Insurance companies felt that these problems hinder their ability to expand insurance services.

4.3 MEDICAL CARE PROVIDERS

The medical care providers who participated in health insurance markets are predominantly large hospitals from the private sector. Virtually all these hospitals are in the urban areas. Moreover, they were being utilized mainly by people in formal employment, confirming that most of the people enrolled in insurance schemes have formal employment in the private and public sector in urban areas. This is the well-known problem of urban bias in economic development in a predominantly rural or agricultural economy.

4.4 THE SPECIAL PROBLEM OF COST ESCALATION

Cost escalation is a common concern to all actors in the health insurance market. It manifests itself in the form of excessive medical bills to the insurers; high costs of providing medical care to the providers; high premium rates; and inadequate coverage against medical bills. Any intervention aimed at arresting the problem of cost escalation will have to include all the actors in the medical insurance market.

4.5 POLICY SCENARIO

The study has focused mainly on the supply side of the health insurance industry by examining in detail insurers and health care providers. Employers who make up only a part of the demand side of the industry have also been studied, however. For the purpose of keeping the scale of the study small, an important component of the demand side which has not been addressed is the individual household insurance user, who is also a potential user of medical insurance.

To formulate a comprehensive policy package for the industry, a thorough analysis of the demand side will be necessary. The study has identified several policy options, but they will need more work to concretize intervention designs:

- ▲ The pervasive aversion to risk taking in the health insurance industry by the insurance companies can be moderated by better information flow between all the actors in the industry. (Only five out of 38 registered insurance companies were running health insurance as "stand-alone" or pure business portfolios.) The

government in concert with the AKI can begin to formulate a program for this purpose. Some of the activities of the program might include:

- △ A campaign to popularize health insurance by disseminating information on existing insurance schemes to the population.
- △ Government and AKI should sponsor production and distribution of booklets and other printed materials on health insurance. These booklets should be written in informal language directed to ordinary people.
- △ Given that cases of AIDS are increasing, insurance schemes to cover costs of treating this catastrophic disease should be explored.
- ▲ Cost escalation cannot be removed permanently from the insurance market but it can be monitored and regulated to prevent it from getting out of hand. A mechanism needs to be set up to monitor the cost escalation problem and intervene when necessary. Appropriate interventions would raise the level of investors' confidence in the insurance industry.
- ▲ The government should regularly make available to the insurance industry information on "the health of the economy" e.g., inflation rates, population-based socioeconomic parameters, and epidemiological data on important diseases.
- ▲ Both fraudulence and mismanagement in the insurance industry, which discourage the would-be insurance buyers and industry investors, should be addressed. The Commissioner of Insurance should establish a broad-based standing force to police and enforce ethics in the industry so as to reduce fraudulence. The force should have legal backing.
- ▲ In the case of NHIF, some of the issues raised in the study have been taken up in the proposed reform of NHIF (NHIF, 1992). These include upward adjustment of premiums and reimbursement rates and decentralization of some of the administration functions of NHIF.
- ▲ This study has not delved into the insurance law, but several observations which could be addressed by adjustment of the law may be made:
 - △ There is need to liberalize the investment policy in respect of premium revenue. At present, there is a legal restriction on the kind of investment for which premium revenue can be used. Insurance firms should be allowed the flexibility to invest the revenues as profitably as possible.

- △ In the short run, the government should give a tax moratorium on profits made on health insurance. The moratorium would need to be reviewed when the industry has expanded.

- ▲ This study has not investigated the rural medical care pre-payment schemes, but it has established that formal market insurance is a small part of non-exchequer finance for health care. It covers mainly the salaried work force. It is almost non-existent in the rural areas. In the short and medium term, there is an urgent need to encourage and support rural community-based schemes because they will have a broad population base. Also to be supported are insurance schemes for small informal businesses in urban areas. The study shows there is great potential in extending medical insurance coverage to those working in such businesses. (About 20 percent of participants in the medical care insurance schemes in our sample were from small or unregistered businesses.)

5.0 SUMMARY AND CONCLUSIONS

This study set out to answer three questions about health insurance in Kenya:

- ▲ Against what type of illness expenses do Kenyans generally insure themselves? How do these differ across social groups?
- ▲ What kind of insurance markets exist in urban and rural Kenya? How do these affect geographical and social distribution of health insurance services?
- ▲ What policy instruments need to be put in place to promote the development of the insurance industry in Kenya? What further policies need to be pursued to ensure equity in health insurance coverage in the population?

The study has not been exhaustive in answering all the aspects of these questions because of resource limitations and because it was not possible to conduct an exhaustive field survey. Paucity of data has also been a limitation. The study has established, however, that there is an active health insurance industry in Kenya, with a small number of insurance companies offering a variety of health insurance packages. Despite the small size of the market, a wide range of medical care cost risks are covered. Medical cost information in the industry in most cases is maintained in medical cost categories rather than in disease categories. Insurance coverage is bought against costs of hospitalization, surgery, medication, and x-rays. In many developing countries, it is the urban population in the formal sector that is insured. But our study also shows that the potential for extending health insurance to the informal sector in the urban areas is substantial. This is a major finding of this study, and merits further scrutiny.

The health insurance industry is facing major problems of a traditional nature, including adverse selection, moral hazard, cost escalation, and administrative burdens. Policy options which need further study have been suggested in areas of dissemination of insurance information, improvements in administration and management of insurance schemes, special insurance schemes for AIDS, monitoring and supervision of the insurance industry, and exploration of rural, community-based insurance schemes, as well as schemes for unregistered small businesses in urban areas.

Finally, we make the observation that market-oriented health insurance will develop only slowly in Kenya, hence the need to explore alternative ways of social financing for health care. One of the crucial analytical needs in this endeavor is to learn about responsiveness to community and household demands for health care and health insurance to the ongoing health care financing policy reforms. For example, it will be important to understand what happens to these demands as user fees are instituted in lower-level facilities in the government health sector, and as medical care costs in the private sector are adjusted due to changes in macroeconomic aggregates, such as inflation and foreign exchange rates.

APPENDICES

**APPENDIX A
TYPES OF POLICIES AND NUMBER OF COMPANIES UNDERWRITING THE INSURANCE**

Type of Policies	No. of Groups	No. of People	No. of Policies	Total Annual Premiums\ Kshs	No. of Companies Writing the Insurance
Marine Insurance	—	—	1,466	215,679,014	13
Motor Vehicle Insurance	—	—	13,716	622,080,297	16
Life Insurance	—	—	2,866	241,339,000	08
Pensions Schemes	—	—	81	358,000,000	04
General\Miscellaneous Insurance	—	—	5,501	306,571,956	11
Public Liability	—	—	1,599	94,582,121	14
Individual Personal Accident	—	—	716	204,784,375	07
Health Insurance	18	700	148	2,000,000	02
Group Insurance Group Medical Scheme	310	201,307	1,467	187,507,688	03
Fire	—	—	7,005	450,913	11

**APPENDIX B
TOTALS OF PATIENTS BY FACILITY TYPE DURING THE YEAR 1992***

Nature of patient Facility Type	Out-patients	In-patients
Hospitals	375,565	76,299
Health Center	4,000	1,200
Private Dispensary	00	00
Nursing Home	2,714	5,920
Maternity Home	6,053	2,330
Totals	388,332	85,749

* All are paying patients because private sector facilities charge for health care. The proportion of the patients who paid through insurance is not known.

**APPENDIX C
HEALTH INSURANCE EXPANSION PROBLEMS OF THE ECONOMY AND THE MARKET**

CONSTRAINTS

1.	Rising costs of medical services
2.	Dishonest clients and/or moral hazard
3.	Low premiums
4.	Documentation is expensive, e.g., the costs of forms that need to be completed and the time it takes to complete them
5.	Income per capita is too low for the people to afford insurance
6.	Premium determination is usually difficult
7.	High claim rate
8.	Reimbursement from NHIF is too low
9.	Health insurance is a high-risk business
10.	People generally have a negative attitude towards insurance (so selling insurance to the public is difficult)
11.	The level of illiteracy is too high (people do not know much about insurance)
12.	The selling of the insurance is done mostly by nonprofessionals (salespersons) who do not have adequate knowledge of insurance
13.	The economy is poor
14.	There is spiralling inflation
15.	Administration expenses are too high

**APPENDIX D
BARRIERS ORIGINATING FROM DIFFICULTIES IN OPERATIONS**

PROBLEM

- | | |
|------------|---|
| 1. | Some claims are difficult to handle, e.g., in determining the exact cause, loss, and manner of compensation |
| 2. | Fraudulence is highly prevalent |
| 3. | Much time and money are spent on loss assessors, adjusters and investigators |
| 4. | Lack of supporting documents or claims details |
| 5. | Improperly completed proposal forms |
| 6. | Delayed disclosures and reporting (poor communication) |
| 7. | Non-compliance with conditions and terms of policies |
| 8. | Inflation problem makes settling the correct claims value difficult |
| 9. | Lack of cooperation between/among interested parties |
| 10. | Fraudulent claims |
| 11. | Lapsed policies (whether to pay or not and if so, how much) |
| 12. | Lack of understanding of the basis of coverage and terms and conditions of the policies by the claimants and, at times, by the insurers themselves |
| 13. | Payment of partial premiums |
| 14. | Lack of late follow-ups on claims |
| 15. | Ignorance of procedures |
| 16. | Pressure to settle claims by claimants |

APPENDIX E EMPLOYERS' PROPOSALS ON HOW IMPROVEMENTS CAN BE ATTAINED IN THE HEALTH INSURANCE INDUSTRY		
Recommendations		Frequency Recommended
1.	Assessments should be done early and fast enough to enable immediate payment.	29
2.	Employers should revise insurance schemes and increase coverage.	13
3.	Abolish coverage restrictions and encourage coverage for everybody willing to enroll in insurance.	12
4.	The government should reveal the rate of inflation to enable insurers to change premiums and benefits appropriately.	04
5.	The labor office should be more efficient. Continuous training and retraining should be encouraged.	02
6.	The scheme should be made commercial and privatized.	02
7.	There is a need to develop a guideline and schedule for compensation.	02
8.	The policy condition, terms, and procedures should be made known to the clients earlier, e.g., at the time of taking the policy.	02
9.	Better schemes with improved terms and conditions need to be developed.	01
10.	Recognized professional doctors should be engaged in the claim assessment and not just any doctor.	01
11.	Experts should advise manufacturers (employers) on security so that they can take up coverage.	01
12.	Government should improve health systems and subsidize insurance.	01
13.	Rebate rates should be directly related to premium contributed.	01
14.	The insurance should cover the immediate family.	01

APPENDIX F STRENGTHS OF NATIONAL HOSPITAL INSURANCE FUND MENTIONED BY EMPLOYERS		
Strengths		Frequency Mentioned
1.	Pays a reasonable proportion of hospitalization bill, hence relieving the members of the heavy financial burden.	50
2.	It is appropriate and beneficial to low-income earners who cannot afford other expensive medical schemes.	08
3.	NHIF is prompt in making payments to hospitals. Members are therefore well attended at the hospitals.	06
4.	It is an affordable way of insuring against cost of ill health.	03
5.	Caters to the entire family's health needs.	02
6.	Members can be admitted to any hospital as long as it is recognized by the NHIF.	02
7.	Being compulsory, it forces employees earning at least Ksh. 1000 monthly to meet payments for insurance coverage.	02
8.	Enables saving for future.	01
9.	Rebates have been improved from minimum of Ksh. 150 to Ksh. 450 per night.	01

APPENDIX G SHORTCOMINGS OF NHIF, AS CITED BY EMPLOYERS	
Shortcomings	Frequency Mentioned
1. Out-patient bills are not covered\does not cover adequately.	24
2. The reimbursement is minimal\not substantial.	22
3. The bureaucracy (red tape) followed when claiming is cumbersome and wastes time.	16
4. The premiums are high while benefits are limited.	16
5. The reimbursements are limited and dependent on the hospitals attended. In some hospitals rebates are too low.	07
6. Card processing, which is done at the headquarters, takes too long.	06
7. Some people contribute and never benefit.	05
8. It favors the rich who can afford to meet the high initial costs like transportation and admission fees.	05
9. Cards are not received on time.	04
10. People do not gain from the scheme; it is therefore useless.	04
11. Registration and renewal of cards is cumbersome.	03
12. It is a form of tax rather than insurance.	03
13. NHIF workers are not dedicated and behave as if they are doing one a favor.	02
14. Claims without an NHIF card take too long.	02
15. The administration of the fund is slow and tedious.	02
16. One does not get the required kind of treatment.	02
17. The claimant may inflate the bill.	02
18. Mismanagement.	02
19. Reimbursement should be based on the categories of employees' contributions so that the higher the amount contributed, the more the rebate entitled to the contributor.	02
20. There are non-claim discounts, like those given in motor insurance.	01
21. The monthly contribution to the fund by employees reduces one's net salary and hence the disposable income subsequently.	01
22. The strict deadlines given for deductions and remittance of contributions is bothersome.	01
23. Wrong people (non-members) are given the cards.	01
24. There is room for fraudulent practices.	01

APPENDIX G SHORTCOMINGS OF NHIF, AS CITED BY EMPLOYERS		
Shortcomings		Frequency Mentioned
25.	If one does not claim over any given period, the amount contributed or at least part of it should be refunded.	01
26.	There are not sufficient checks made to ensure that NHIF stamps are not sold by unscrupulous persons.	01
27.	One has to be hospitalized to benefit from NHIF.	01
28.	The services are below standard.	01
29.	It does not cover drugs and consultancy.	01
30.	Most workers are low-income earners and cannot make use of funds as they cannot afford to go to expensive private hospitals.	01
31.	If one does not claim, the money is lost.	01
32.	Patients whose contribution is not received in the month they need benefits do not receive them.	01
33.	Age factor is used to exclude some of the children, especially those over 18 years, yet some of them are not independent.	01
34.	It is more of an accommodation scheme than a medical scheme.	01
35.	It is not flexible in cases of change of the maiden name.	01

**APPENDIX H
SUGGESTED IMPROVEMENTS TO NHIF AS GIVEN BY EMPLOYERS**

Suggested Improvement	Frequency Mentioned
1. Compensation should be increased.	19
2. Should also cover the out-patient.	15
3. The fund should pay for the total bill, i.e, the correct amount.	13
4. Services should be improved, e.g, by decentralizing them to achieve efficiency.	13
5. Claims settlement should be faster.	10
6. The contributions should be lowered and fixed for everybody.	08
7. Should be extended to cover doctors' fees, drugs, surgery, etc.	07
8. NHIF personnel should be more professional and straightforward. They should change their undesirable and corrupt attitudes.	06
9. Make the method of obtaining cards easier.	06
10. The refundable amount should be in line with the market rate.	05
11. There is a need to make an immediate rebate to the hospital. Prompt issue of rebates should be encouraged.	05
12. It should pay at least 50% of all bills, including medicine, doctors' fees, etc.	04
13. Make compensation proportionate to the contribution.	03
14. Contributions should belong to the contributors, just like in NSSF.	03
15. Strengthen the fund administration.	03
16. The fund should cover the whole family, including children over 18 years.	03
17. Invest the NHIF revenue wisely to maximize returns and thus provide more benefits to contributors.	02
18. The records should be computerized.	02
19. Should be structured like an insurance scheme whereby people can claim for other medical expenses.	02
20. It should cover hospital deaths.	02
21. The fund should cover out-patients' services.	02
22. They should substitute stamp system with a certificate system.	02
23. There should be a "No Claim Discount."	01
24. Increase the percentage of coverage.	01

**APPENDIX H
SUGGESTED IMPROVEMENTS TO NHIF AS GIVEN BY EMPLOYERS**

Suggested Improvement	Frequency Mentioned
25. Should also cover the small private clinics.	01
26. Should pay for specialized treatment.	01
27. The scheme managers should not misuse money received from the contributor.	01
28. The scheme should cover those earning less than Ksh. 1000 per month.	01
29. Retrain the management.	01
30. Should provide loans to contributors.	01
31. Should benefit the contributors who do not fall sick over the period of insurance.	01
32. The scheme should be run like motor insurance: third party coverage where the contributor pays, for instance, only the first Ksh. 2000 of the medical bills and the NHIF pays the rest.	01
33. It should be managed as a proper insurance scheme.	01
34. They should have their own hospitals where the members could seek medical attention.	01
35. The fund should be turned into a cooperative so that the members can benefit. It should operate freely without government influence.	01
36. Compensation should be a big fraction of the total contribution.	01
37. The NHIF should employ own management consultants and/or have private auditors.	01

**APPENDIX I
SURVEY INSTRUMENTS**

**SURVEY INSTRUMENT I:
EMPLOYERS' QUESTIONNAIRE**

NAME OF INTERVIEWER _____ Date _____

1. Questionnaire Number _____

2. Name of company _____

3. Location of company: 1. Urban 2. Rural

District _____

4. Designation of the respondent:

- 1. Manager
- 2. Director
- 3. Personnel Officer
- 4. Public Relations Officer
- 5. Other (specify) _____

5. Nature of the company:

Principal type of business:

A) Agriculture:

- 1. Plantations (tea, coffee)
- 2. Dairy
- 3. Horticulture
- 4. Food processing
- 5. Other (specify) _____

B) Manufacturing:

- 1. Agro-Industry
- 2. Metalworks
- 3. Textile and garments
- 4. Furniture and woodwork
- 5. Chemicals and pharmaceutical
- 6. Other (specify) _____

C) Service:

1. Banking
2. Transport
3. Commercial/trade
4. Civil service
5. Public service
6. Local authorities
7. Hotels and restaurants
8. Other (specify) _____

D) Informal sector:

1. Food processing
2. Repairs/metal works
3. Textiles and garments
4. Catering services
5. Furniture and woodwork
6. Motor vehicle repair
7. Transport
8. Other (specify) _____

6. Business ownership:

1. Private (Kenyan)
2. Private (Foreign)
3. Parastatal
4. Government institution
5. Joint venture
6. Cooperative
7. Other (specify) _____

7. A) What is the current number of employees by category?

Category	Males	Females	Total
1. Casuals			
2. Permanent: Non-management Management			

B) What is your total wage bill for:

Category	Males	Females	Total
1. Casual			
2. Permanent: Non-management Management			

C) What is the minimum and maximum wage for:

Category	Minimum wage		Maximum wage		Total
	Males	Females	Males	Females	
1. Casuals					
2. Permanent: Non-management Management					

8. A) Do you have a health insurance scheme/coverage for your employees ?

1. Yes _____ 2. No _____

(If No, go to question 15)

B) If Yes, what insurance schemes do you have?

1. NHIF
2. Workmen's Compensation
3. Group medical
4. Individual health insurance scheme

C) Other medical care arrangement made by the employer:

1. Company-sponsored clinic
2. Arrangement for treatment at different health facilities
3. Reimbursement after treatment

NHIF

9. A) When was NHIF started by your company?

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B) How many workers are covered?

Category	Males	Females	Total
1. Non-Management			
2. Management			

C) What is the total wage bill for those who contribute to NHIF?

Category	Total Wage Bill
1. Non-Management	
2. Management	

D) What is the minimum and maximum wage for:

Category	Minimum Wage	Maximum Wage
1. Non-Management		
2. Management		

E) How many claims did your employees make last year under this scheme?

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10. A) What are the strengths of NHIF?

B) What are the shortcomings?

C) What improvement would you like to see in the NHIF insurance scheme (list in order of importance)?

OTHER INSURANCE SCHEMES

11. A) How many workers are covered by insurance schemes other than NHIF?

Schemes	Non-Management	Management	Date Started
1. Workmen's Compensation			
2. Group Medical			
3. Individual Medical			
4. Group Accident, Death/Disability			
5. Other			

B) How often are the premiums paid and how much are they?

Scheme	1. Monthly 2. Quarterly 3. Semi-annually 4. Annually	Total Premiums (Ksh.)
Workmen's Compensation		
Group Medical		
Individual Medical		
Group Accident, Death and Disability		
Other		

C) Who contributes to this scheme ?

Scheme	Employee Only	Employer Only	Total Premiums (Ksh.)
Workmen's Compensation			
Group Medical			
Individual Medical			
Group Accident, Death and Disability			
Other			

D) What type of health problems are covered?

Schemes	Accidents	Normal illness	Chronic condition	All
Workmen's Compensation				
Group Medical				
Individual Medical				
Group Accident, Death and disability				
Other				

E) What are the benefits:

	Workmen's Compensation	Group Medical	Individual Medical	Group Accidental Death/Disability
1. Hospitalization				
2. Out-patient				
3. Surgery				
4. Medication				
5. Consultation				
6. Laboratory				
7. X-rays				
8. Loss of limbs				
9. Death				
10. All the above				
11. Other (specify)				

F) How many claims did your employees make last year under these schemes?

Claims	Workmen's Compensation	Group Medical	Individual Medical	Group Accidental Death/Disability
Number of claims				
Their total value (Ksh.)				
Number Honored				

Why were others not honored?

12. With which company(ies) have you insured?

Name	Public/Private Ownership
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

13. What are the shortcomings in these schemes?

- 0. None _____
- 1. Workmen's Compensation _____
- 2. Group medical _____
- 3. Individual medical _____
- 4. Group, accident, and death _____

14. What improvement would you like to see in these insurance schemes (in order of importance)?

- 0. None _____
- 1. Workmen's Compensation _____
- 2. Group medical _____
- 3. Individual medical _____
- 4. Group, accident, and death _____

(Go to question 18)

THOSE COMPANIES WITH NO INSURANCE SCHEMES

15. A) Why don't you have health insurance for your employees?

- 1. _____
- 2. _____
- 3. _____

B) In the future, would you like to introduce health insurance schemes other than NHIF for your employees?

Yes _____ No _____

C) If yes, what kind of health problems would you like to see covered in the health insurance scheme?

- 1. Hospitalization for employee and family
- 2. Injuries at place of work
- 3. Out-patient services
- 4. Dental services
- 5. Other (specify) _____

16. What insurance coverage do you prefer for your workers: individual, group, or both?

- 1. Individual
- 2. Group
- 3. Both

Explain _____

17. What mode of contribution would you prefer?

- 1. Employee only
- 2. Employer only
- 3. Government only
- 4. Employee and Employer

18. What are your views on health insurance for workers in your company?

19. Who would you like to handle health insurance in Kenya?

- 1. Private insurance companies

Explain _____

- 2. Government

Explain _____

- 3. Parastatal insurance company

Explain _____

4. Non-government organizations (NGOs)

Explain _____

5. Others (specify) _____

**SURVEY INSTRUMENT II:
INSURANCE COMPANIES' QUESTIONNAIRE**

NAME OF INTERVIEWER _____ Date _____

1. Questionnaire Number □ □ □

2. Name of company:
 a) _____
 b) Date of establishment _____

3. Location of company: 1. Urban _____ 2. Rural _____ □
 District _____

4. Designation of the respondent:
 1. Manager □
 2. Director □
 3. Personnel officer □
 4. Public relations officer □
 5. Other (specify) _____ □

5. Ownership of insurance companies (1991):

Ownership		Total Assets (Ksh.)
Foreign Percent	Local Percent	

6. Insurance policy offered in 1991:

Type of Policies	Number of Policies	Annual Premiums
1. Marine 2. Motor V.I. 3. Life Insurance 4. Pensions 5. General Insurance 6. Public Liability 7. Personal Accident a) Pure Personal b) Health Insurance c) Group Health Insurance 8. Fire		

7. A) For companies not offering group or individual health insurance, are there plans to enroll?

Yes _____ No _____

B) If No, what are the reasons?

8. How are health insurance premiums determined in your company?

1. The firm decides
2. Insurance firm consult other insurance
3. Government decides
4. Fixed cooperatively between government and insurance companies
5. Other (specify) _____

9. Number of health policies and their total value sold by your company in the last 10 years?

Year	Group Policies			Individual Policies		Personal Accident	
	No. of Groups	No. of People	Total Premiums	No. of Policies	Total Premiums	No. of Policies	Total Premiums
1980							
1981							
1982							
1983							
1984							
1985							
1986							
1987							
1988							
1989							
1990							
1991							

10. What proportion of your clients are in:

A) Urban Areas

--	--	--	--	--

B) Rural Areas

--	--	--	--	--

11. How many clients did you recruit last year in:

A) Urban Areas

--	--	--	--	--

B) Rural Areas

--	--	--	--	--

12. Do you have health insurance policy to cover the following:

1. Individual separately

2. Individual and spouse

3. Individual, spouse, and nuclear family

4. Groups (e.g., church groups)

5. Others (specify) _____

13. A) How many health insurance claims have you received annually in the last ten years?

Year	Number of Claims			Total Value (Ksh.)			Total Number of Claims Honored			Total Value of Claims Honored		
	Group	Individual	Personal	Group	Individual	Personal	Group	Individual	Personal	Group	Individual	Personal
1980												
1981												
1982												
1983												
1984												
1985												
1986												
1987												
1988												
1989												
1990												
1991												

B) List four main reasons why claims were not honored in the last 12 months

Reasons	Frequency (number)	Value (Ksh.)
a) Group		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

(continued on next page)

Reasons	Frequency (number)	Value (Ksh.)
b) Individual		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
c) Personal		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

C) What is the average period (in months) for settling a claim?

D) What problems do you encounter when settling claims (list three in order of importance)?

1. _____
2. _____
3. _____

14. A) What proportion of your annual insurance premiums do health insurance premiums constitute on the average?

B) Has the annual proportion been rising or falling in the last 10 years?

		1	2	3	4
		Falling	Constant	Increasing	Don't Know
1. As percentage of total policies	Group				
	Individual				
2. As percentage of total value of insured in the company	Group				
	Individual				

C) How do you rate the potential of health insurance in Kenya?

a) Urban area

1. High
2. Low
3. None

Explain _____

b) Rural area

1. High
2. Low
3. None

Explain _____

D) What constraints do you face in the provision of health insurance (list three in order of importance):

1. _____
2. _____
3. _____

E) What measures do you think should be taken to ease the constraints that you face (list three in order of importance):

1. _____
2. _____
3. _____

F) How would you describe the current health insurance market in Kenya (competitive, monopolistic, oligopolistic, other (specify)):

15. A) Do you sell insurance through insurance agents/brokers?

Yes _____ No _____

B) If yes, how many do you use?

--	--	--	--

C) Where are they located (specify the number)?

Rural _____
Urban _____

D) What special role do brokers/agents play in the marketing of health insurance?

1. _____
2. _____
3. _____

E) Have they been successful in selling health insurance policies?

1. Yes _____ 2. No _____

Explain _____

F) Are there any problems associated with selling health insurance through agents?

1. Yes _____ 2. No _____

Explain _____

G) What is the current level of commission that you give to the agents/brokers?

Agent
Brokers

H) How is this commission determined?

1. Through negotiations between a company and its agents
2. By the company
3. By the agent
4. By agreement between all the insurance companies
5. Ruling market rates
6. By the commissioner of insurance
7. Other (specify) _____

16. What is the market share of the top five health insurance companies in Kenya's health insurance industry?

Name of Company	Share Percentage
1.	
2.	
3.	
4.	
5.	

**SURVEY INSTRUMENT III:
INTERVIEW SCHEDULE WITH COMMISSIONER OF INSURANCE**

1. Name of interviewer _____ Date _____

2. Designation of the respondent:

1. Commissioner

2. Other (specify) _____

3. How many insurance companies do we have in Kenya at present? _____

4. A) What are the main categories of insurance in Kenya?

1. _____

2. _____

3. _____

B) Trend of insurance growth in the last ten years (1980-1991):

Number and Category of Insurance								
Year	Marine	Motor V.I.	Life Insurance	Pensions	General Insurance	Public Liability	Personal Accident	Fire
1980								
1981								
1982								
1983								
1984								
1985								
1986								

Number and Category of Insurance								
Year	Marine	Motor V.I.	Life Insurance	Pensions	General Insurance	Public Liability	Personal Accident	Fire
1987								
1988								
1989								
1990								
1991								

5. A) Give a brief history of insurance in Kenya:

B) Give a brief history of health insurance in Kenya:

6. A) How many companies specialize in health insurance in the country at present?

B) Who are they?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

C) Which companies offer health insurance together with other services?

	Name of Company	Ownership	Location	Total Assets (Ksh.)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

7. How are health insurance premiums determined in Kenya?

1. Each firm individually
2. Insurance firms consult each other
3. Government alone
4. Fixed cooperatively between government and insurance companies

8. How many insurance agents and brokers are registered through the commissioner of insurance?

9. A) What is the future potential of health insurance in Kenya?

1. High ____ 2. Low ____ 3. None ____

Explain _____

B) Is the current potential in health insurance fully exploited?

1. Yes ____ 2. No ____

C) If No, what are the constraints (in order of priority)?

Constraints	Means of Removing Them
1. _____	_____
2. _____	_____
3. _____	_____

10. How best would you describe the current health insurance market in Kenya (competitive, monopolistic, oligopolistic, other (specify)):

**SURVEY INSTRUMENT IV:
HEALTH CARE PROVIDERS' QUESTIONNAIRE**

NAME OF INTERVIEWER _____ Date _____

1. Questionnaire Number □ □ □

2. Name of facility _____

3. Location Facility:

1. Urban □

2. Rural

4. Type of facility:

1. Hospital □

2. Health center

3. Private dispensary

4. Nursing home

5. Other (specify) _____

5. A) Designation of the respondent: □

1. Chief Administrator

2. Director

3. Personnel officer

4. Public relations officer

5. Accountant

6. Other (specify) _____

B) State the volume of patients over the past 12 months:

In-patients □ □ □ □

Out-patients □ □ □ □

C) What is your consultation fee (Ksh)? □ □ □ □

D) What is your rate for the general ward?

--	--	--	--

E) What is your daily rate for special rooms?

--	--	--	--

NHIF HEALTH INSURANCE SCHEME

6. Do some of your clients pay their bills through NHIF?

1. Yes 2. No

If Yes, how many of your patients paid their bills through NHIF in the last 12 months?

--	--	--	--

7. Of the in-patient cases who paid their bills through NHIF in the last 12 months, what proportion came from the following:

- 1. Companies
- 2. Government
- 3. Parastatals
- 4. private groups
- 5. NGOs
- 6. Private individuals
- 7. Others (specify) _____

8. What proportion of your revenue came from NHIF in the last 12 months?

--	--

9. Has the proportion been increasing or decreasing during the past five years?

- 1. Increasing
- 2. Decreasing
- 3. No change

INSURANCE COMPANIES OTHER THAN NHIF

10. A) Do some of your clients pay their bills through insurance other than NHIF?

1. Yes 2. No

B) If Yes, how many cases paid through these insurance in the last 12 months?

--	--	--	--

11. What proportion of revenue came from other health insurance companies' payments in the last 12 months?

--	--

12. A) Which services do patients normally pay for through insurance?

1. Hospitalization
2. Consultations
3. Drugs
4. Surgery
5. Out-patient
6. X-rays
7. Laboratory
8. Other (specify) _____

B) List the top three of these services in terms of the amount of money collected annually:

1. _____
2. _____
3. _____

13. Of the cases that paid their bills through insurance in the last 12 months, what proportion came from the following:

1. Companies
2. Government
3. Parastatals
4. Private groups
5. NGOs
6. Private individuals
7. Others (specify) _____

14. Has the proportion of revenue from insurance been increasing or decreasing during the past five years?

--

1. Increasing
2. Decreasing
3. No change

15. What are the arrangements for payment of hospital bills?

1. Direct contact with insurance company
2. Employer authorizes insurance company to pay
3. Individuals make own arrangements
4. Employer/Employee/Insurance Company
5. Other (specify) _____

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