Is social health insurance the magic bullet to achieving Universal Health Coverage?
A case to reduce direct out of pocket payments

Authors: Njuguna David, Dr Elizabeth Wangia, Pepela Wanjala and Kumiko Yoshida

Key Messages
• In the 2018 KHHEUS study, twenty eight percent of Kenyans do not have access to health care despite reporting illness, with one out of five of these citing “high cost of care” as the main reason.

• In 2018/19, households contributed 24.3 percent of current health expenditures through direct out of pocket payment, while social health insurance controlled 13.8 percent.

• The insurance penetration has gradually increased to 19.9 percent in 2018, up from 17.1 percent in 2013. The highest penetration is seen among the educated, those in the higher wealth quintile and those in the urban areas.

• Self-medication was the main reason for not seeing the health care providers and it has increased from 30 percent in 2013 to 45 percent in 2018. Purchase of medicines without prescription may initially be a cheaper option for those who do not have health insurance, but the subsequent delay in seeking professional care could have detrimental effect if there’s no early detection of diseases. This finding calls for a behavior change both among the clients and health service providers.

Introduction
Kenya has committed to achieve UHC as evidenced by the strong political commitment exemplified in the governments Big 4 Agenda that includes healthcare as a key priority.

Given the importance of UHC as a global and national agenda, there’s need to review and measure the country’s progress towards UHC over time.

Monitoring financial protection focuses on direct out-of-pocket (OOP) spending made at the time of service use, which could deter people from seeking the care they need, or may suffer severe financial hardship as a result of making such payments.

Risk pooling through health insurance can alleviate some financial barriers and increase access to healthcare services.

Social Health Insurance is one of the five possible methods of financing health care—the others are direct payment by the patients in the form of user fees, tax-financing by government based on general taxation, private health insurance which is profit driven and open to those who can afford prescribed premiums and community health insurance whose membership is based on community-based initiatives.
Background and Context

The momentum towards Universal Health Coverage (UHC) is growing within Africa as an important public policy agenda. UHC means ensuring that all people have access to needed health services of sufficient quality and ensuring that the use of these services does not expose the user to financial hardship (WHO, 2013).

The right to quality affordable health care as envisaged in the Constitution of Kenya 2010 can only be achieved through a concerted effort not only of the National and County Governments, but also with the various stakeholders. While the national government must lead in provision of affordable healthcare for all, it is evident that it has to be supplemented and complimented by various stakeholders.

Overall health outcomes have improved in Kenya, although there exist disparities within and among counties. Initiatives have been put in place to cushion the population from the cost of healthcare including introduction of free maternity services to reduce financial barriers for pregnant mothers and newborns to access the skilled delivery and facility-based care; removal of user fees at primary care facilities; expansion of insurance coverage into the informal sectors; and provision of insurance for indigent and vulnerable populations.

The three goals of UHC are for all citizens to have access to the health services they need be financially protected from the consequences of ill-health and improve quality of healthcare services. These goals are considered in terms of three dimensions as shown in Figure 1, which look at:

- **Breadth of coverage for health services:** proportion of the population that has access to the health services that they need.
- **Depth of coverage for the health services that are provided:** how many conditions or interventions are included in the package of health.
- **Height of coverage** for the included conditions or interventions: what proportion of the cost is covered.

According to the WHO Global Health Expenditure database, Kenya’s economy has been steadily growing which encouraged increase of per capita health spending, as well as the proportion of government health spending over current health spending. The proportion of Out-of-pocket expenditures in the current health expenditures has almost halved in 2019 (24.3%) compared to 2000 (47.1%). (Table 1)

**Table 1: Key health expenditure statistics of Kenya (2000 – 2019)**

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2006</th>
<th>2012</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health spending US$ per capita (CHE)</td>
<td>21</td>
<td>40</td>
<td>64</td>
<td>83</td>
</tr>
<tr>
<td>Government health spending % Health spending (GGHE-D%CHE)</td>
<td>28.6%</td>
<td>24.8%</td>
<td>32.4%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Out-of-pocket spending % Health spending (OOPS%CHE)</td>
<td>47.1%</td>
<td>38.4%</td>
<td>31.6%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Priority to health (GGHE-D%GGE)</td>
<td>7.1%</td>
<td>6.8%</td>
<td>7.5%</td>
<td>8.3%</td>
</tr>
<tr>
<td>GDP US$ per capita</td>
<td>442</td>
<td>686</td>
<td>1,137</td>
<td>1,817</td>
</tr>
</tbody>
</table>

Source: WHO Global Health Expenditure database
Methodology
This policy brief was informed by findings from the National Health Accounts (NHA) 2021 for Financial Years 2016/17 to 2018/19, as well as evidence from other health sector documents that assessed the health sector performance. Publications on access to health services were also used to corroborate the findings. The Kenya National Health Accounts (NHA) estimation was undertaken in order to track the flow of funds to the health sector.

The key findings are presented, as well as recommendations to support policy makers in designing and implementing UHC reforms.

Results/Findings

i. OOP trend in NHA
According to National Health Accounts (NHA) 2021, the households as financing agents\(^1\), through out-of-pocket expenditures and non-profit institutions serving households, controlled 24.3 percent and 16.2 percent of CHE respectively in 2018/19 down from 23.3 percent and 17.7 percent in 2016/17. (Figure 2)

![Figure 2: Financing agents of CHE in absolute values (in KShs million)](image)

The MOH increased their role as a financing agent to 15.3 percent of Current Health Expenditures (CHE) in 2018/19 from 14.9 percent in 2016/17; while counties role decreased to 18.3 percent in 2018/19 as compared to 19.3 percent in 2016/17. Social Health Insurance increased gradually from 10.3 percent in 2016/17 to 13.8 percent in 2018/19.

In absolute values, the MOH, the CDOH and other government entities continue to control a large percentage of CHE. The role of social health insurance in managing funds for health increased by 55 percent between 2016/17 and 2018/19, closing the gap between the National Ministry of Health funding. NGOs (NPISH) increased by 5.6 percent while households through Out of pocket spending (OOP) increased by 21% over the same period. (Table 2)

**Table 2: Financing agents of CHE in absolute values (in KShs million)**

<table>
<thead>
<tr>
<th>Financing agents</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health-National</td>
<td>57,638.0</td>
<td>66,806.9</td>
<td>68,287.5</td>
<td>18.5%</td>
</tr>
<tr>
<td>Other ministries and public units (belonging to central government)</td>
<td>332.4</td>
<td>318.3</td>
<td>299.3</td>
<td>-9.9%</td>
</tr>
<tr>
<td>County Department of Health</td>
<td>74,679.9</td>
<td>82,101.9</td>
<td>81,627.0</td>
<td>9.3%</td>
</tr>
<tr>
<td>Social Health Insurance Agency</td>
<td>39,840.2</td>
<td>51,091.0</td>
<td>61,753.1</td>
<td>55.0%</td>
</tr>
<tr>
<td>Commercial insurance companies</td>
<td>47,261.0</td>
<td>37,148.8</td>
<td>45,166.7</td>
<td>-4.4%</td>
</tr>
<tr>
<td>Parastatals</td>
<td>7,340.1</td>
<td>6,713.0</td>
<td>6,780.2</td>
<td>-7.6%</td>
</tr>
<tr>
<td>Private employers</td>
<td>1,166.5</td>
<td>2,705.4</td>
<td>2,305.9</td>
<td>57.7%</td>
</tr>
<tr>
<td>Non-profit institutions serving households (NPISH)</td>
<td>68,505.2</td>
<td>68,899.8</td>
<td>72,357.6</td>
<td>5.6%</td>
</tr>
<tr>
<td>Households</td>
<td>90,050.2</td>
<td>95,562.6</td>
<td>108,683.2</td>
<td>20.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>386,813.4</strong></td>
<td><strong>411,347.8</strong></td>
<td><strong>447,260.5</strong></td>
<td><strong>15.6%</strong></td>
</tr>
</tbody>
</table>

Source: NHA 2021

**ii. Per capita health expenditure trends**

The per capita expenditure on health for the year 2018 was estimated at KSh 2,470, comprising KSh 1,941 and KSh 529 for outpatient and inpatient expenditures respectively (Figure 3).
This is a 53 percent increase from the findings of 2013 where the per capita expenditure was estimated at KSh 1,609, comprising KSh 1,254 and KSh 355 for outpatient and inpatient respectively.

### iii. Three dimensions of UHC

#### iii-1. Access to health care services

The breadth of access to health services for Kenyans can be assessed by evaluating whether households were able to access services when they needed them.

According to KHHEUS, both in 2013 and 2018, 19.3% of the households reported having been sick in the four weeks preceding the survey. Out of those, 28 percent did not seek health care in 2018. This is an increase from 12.7 percent in 2013. The three top reasons for not seeking care are given in Table 3.

“Self-medication”, and “illness not considered serious enough” are the two main reasons that were given by 70% of the respondents, followed by “high cost of care” for about 20%.

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**Table 3: Reasons for not seeking treatment despite illness (2003 – 2018)**

<table>
<thead>
<tr>
<th>Reasons</th>
<th>2003</th>
<th>2007</th>
<th>2013</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-medication</td>
<td>34.3</td>
<td>30.4</td>
<td>39.7</td>
<td>45.2</td>
</tr>
<tr>
<td>Illness not considered serious enough</td>
<td>7.9</td>
<td>0.1</td>
<td>39.3</td>
<td>24.8</td>
</tr>
<tr>
<td>High cost of care</td>
<td>36.3</td>
<td>37.7</td>
<td>21.4</td>
<td>19.4</td>
</tr>
<tr>
<td>Long distance to provider</td>
<td>15.1</td>
<td>11.2</td>
<td>1.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Religious / cultural reasons</td>
<td>1.1</td>
<td>3.1</td>
<td>0.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Fear of discovering serious illness</td>
<td>1.1</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Poor quality service</td>
<td>1.6</td>
<td>0.5</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Other reasons</td>
<td>2.6</td>
<td>12.8</td>
<td>6.2</td>
<td>4.1</td>
</tr>
</tbody>
</table>

**Source:** KHHEUS, 2018

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**iii-2. Health benefit package**

According to the KHSSP MTR conducted in 2021, two key indicators: “the health facility density per 10,000 population”, and “the number of health facilities per 10,000 population”, saw an improvement, and are on track to meet the target (the target for facility density is 2.4; the number of beds is 18).

Coverage of essential health services\(^2\) was at 83.3 percent nationally, while 20 counties scored above the national average (Figure 4). The counties in the ASAL region are having challenges as seen from the KHSSP MTR UHC service coverage index 2019/20, using the WHO estimation method.

**Figure 4: UHC service coverage index score by county**

\(^2\)Essential health services include: Reproductive, maternal, newborn and child health, infectious disease control, Non-communicable diseases

**Source:** KHSSP MTR Statistical Report 2021
Findings from NHA 2021 revealed that Capital formation also doubled its share in comparison to 2015/16 NHA, with the government as the predominant contributor.

The above finding may explain well the public sector’s increased investment on health after devolution, which led to the expansion of health services.

**iii-3. Financial Risk Protection**

The trend in the proportion of households with a form of social protection against healthcare payments were used to track the extent of financial risk protection.

**Insurance coverage**

Health insurance plays a key role in accessing health care by cushioning households from incurring high out of pocket expenditure that could lead them into poverty. According to the KHHEUS 2018, health insurance coverage increased from 17.1 percent in 2013, to 19.9 percent in 2018, though the overall coverage is still quite low (Figure 5).

*Figure 5: Health insurance coverage by income groups*

![Health insurance coverage chart](chart.png)

Source: KHHEUS 2018

The KHHEUS 2018 also indicates that the lowest wealth quintile had the lowest insurance coverage at 4.5 percent while the highest wealth quintile had the highest insurance coverage at 42.3 percent indicating wealth affects uptake of health insurance.

In absolute numbers, this coverage of insurance represents 9.5 million Kenyans out of the estimated 47.8 million national population for the year 2018. This shows that the majority of Kenyans have no form of social protection against health care expenditure, and is well corroborated by the high number of households that reported not seeking care, citing lack of money (19.4 percent) as the main reason.

In addition, urban areas had an insurance penetration rate of 29.7 percent as compared to rural areas at 14.3 percent. Those with university education had higher protection at 50.4 percent, while the lowest coverage was reported among those with informal education at 4.9 percent. Those in formal employment had the highest coverage at 60.6 percent while the lowest was among those seeking work at 10 percent. NHIF remains the largest insurer accounting for 89.4% of those who reported having health insurance. This points to the critical role that NHIF could play as a vehicle towards achieving UHC.

**Recommendations**

1. The households of lower wealth quintiles, those living in rural areas, and in informal employment, are paying higher % of OOP relative to their income than their wealthier counterparts. The government need to target those who have poor insurance penetration to provide an affordable social health insurance. Increase the population who are covered by social health insurance will reduce the direct out-of-pocket expenditures by the patients while improving the medical cost recovery by the service providers.
2. The coverage of health services offered as well as the quality of services provided should also be improved at health facility level. Quality of care on both clinical quality of care and responsiveness to the patients have been seen as a potential barrier for seeking the health services.

3. Strengthen the regulators’ interventions for quality improvement measures such as mandatory assessment of quality of care at the time of licensing, as well as contracting with insurers, coupled with continuous quality monitoring and medical claim spot-checks will better protect the patients from making ill-informed decisions based solely on their own perception.

4. Strengthen the stewardship role of both the national and the county governments to ensure that only the healthcare providers who offer quality care and improved health outcomes are operational.

5. Avoid fragmentation of financing systems into separate schemes with different levels of funding and benefits for different population groups while targeting resources to remove financial barriers facing the poor and most vulnerable. For instance, NHIF should reduce the number of insurance schemes, in order to enhance cross-subsidization of individual financial risks.

Conflict of Interest

The authors declare no conflict of interest.

References

- WHO Global Health Expenditure database, Kenya country profile: https://apps.who.int/nha/database/country_profile/index/en