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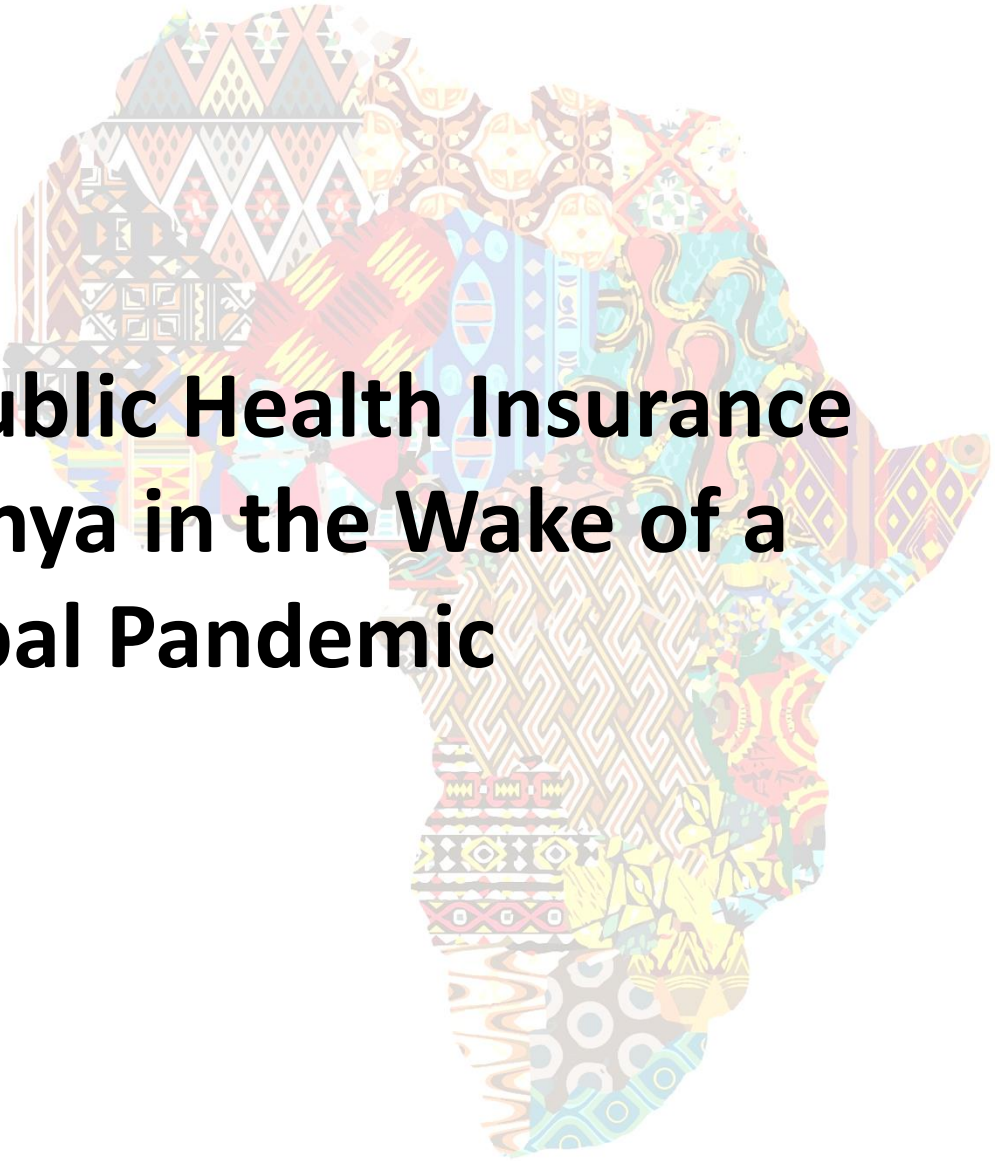
Rethinking Public Health Insurance Cover in Kenya in the Wake of a Global Pandemic



- The study focused on rethinking public health insurance cover in Kenya in the wake of a global pandemic.
- Access and utilization to healthcare services during a global pandemic is vital not just in Kenya but in the region and Africa as a whole.
- Covid-19 has resulted in health care burden not only in the urban areas, but also in the urban centres as well.
- The notion of health insurance is returning at the core of human development debate both locally and at the national level in the wake of high cost of care.

- The outbreak of the pandemic came at a time the medical sector had been facing various challenges over a period of time, including, a series of industrial action by the medical personnel over poor working conditions, poor remuneration, insufficient medical staff among others.

- Government response to the pandemic was hindered with bureaucracy and corruption within the state agencies tasked with procuring equipment needed for combating the pandemic.

- As a Cash Transfer (CT) programme, National Hospital Insurance Fund (NHIF), has been in existence in Kenya for decades (Ikiara, 2009).
- At its inception, the NHIF (a social insurance scheme) was to assist state employees gain access to higher quality private hospitals, thereby relieving congestion in the free public hospitals (Owino *et al.,* 2000).
- In addition, the National Government Constituencies Development Fund, a constituency-devolved fund in Kenya, allocates 35% of its budget for social security to enable community members to pay for the NHIF using the fund (Ndirachu, 2015).

- According to the Ministry of Health (MoH), about one in five Kenyans (17.1%) has some form of health insurance coverage (MoH, 2015).

- The NHIF covers over 88% of the insured, while private insurance covers 9.4%, followed by community-based insurance, which covers 1.3%.

- Since it was introduced, the NHIF has struggled to cater to the growing population and the growing health care needs of Kenyan citizens (Ouma, *et. al.,* 2021).

- Mwabu *et al.* (2004) report that, government health centres and dispensaries cannot be reimbursed by NHIF as it is restricted for use at hospitals.

- Furthermore, the poor who prefer local clinics and dispensaries, which are not registered by the fund, rarely use most of the fund's registered health facilities.

- Further, the increase in the number of people covered with private insurance is stunted by high risks resulting from administrative inefficiency (Hook and Werner, 2003).

- Furthermore, insurance firms are burdened by an overload of correspondence with healthcare providers on claims.

- Lorber and Moore (2002) report that health insurance rest on the edifice of the male.

- For women, having financial resources does not guarantee good healthcare. Even with private insurance, it is often difficult to get payment for preventive procedures (Dina and Law, 1998).

- Further, because insurance coverage is often linked to employment and because women are more likely to be part-time employees, temporary or service workers, or unemployed heads of households, they number prominently among the uninsured.

- The pandemic has greatly undermined health insurance coverage and led to high cost of care not just in developing countries, but also in the developed world (Blumenthal, *et. al.,* 2020; Woolhandler, & Himmelstein, 2020).

- Historically, health care has been relatively immune from recessions as people get sick during both good and bad times, so demand for medical care is relatively constant across the business cycle (Cutler, 2022).

- However, the COVID-19 pandemic, curtailed outside activities, people postponed all kinds of care, from office visits to imaging procedures to filling prescriptions for medications (*ibid*).

- Kenya reported its first case on 13th March 2020, and as of 24th August, there were 229,628 confirmed cases and 4,528 fatalities (MOH, 2021).

- There has been three waves of the pandemic in the country, with the first peaking in July/August 2020.
- The second peaking in October/November 2020
- The third one peaking in March/April 2021 with a high proportion of asymptomatic cases and a lower incidence of severe disease hospitalizations and deaths (see Barasa, *et. al*., 2021).

- Kenya has two types of health insurance cover, namely private and public. Private insurance is available in the form of cooperate cover as well as individual cover.

- Public health insurance is the oldest, established in the 1960s (Ikiara, 2009). It has since gone through changes endeavored to make it a universal cover. It has an ordinary cover and enhanced cover, which functions more less like private insurance.

- The enhanced cover is offered to corporates while the ordinary cover is a paid for as statutory deduction for those in formal employment or out of pocket monthly payment for those in the informal sector.

1. Overview of the Responses
    1. The interviews were conducted with 16 respondents.
    2. Half of the respondents had been in private hospitals while the other half had been in public.
    3. Of the respondents who sought public care, 4 of them had ordinary public insurance while the other 4 had both private and ordinary public insurance.
    4. Over half of the respondents (5) who sought private care had both private and ordinary public health insurance, while the rest (3) had only private insurance or enhanced public health insurance.
    5. Over half (6) of those who went to private care facilities went there out of choice while the other 2, went there because the public facilities were full.
    5. All the respondents interviewed from the public facilities had chosen them for care.
    6. Ordinary public health insurance paid part of the Covid-19 care bills in private and public care facilities.
    7. Most of the private health insurance did not cover Covid-19 treatment in either public or private facilities.
    8. Some private health insurance companies covered partly for Covid-19 treatment in private hospitals.
    9. Some private health insurance paid wholly for Covid-19 treatment in public hospitals.

Conclusion

- At the onset of the Covid-19 pandemic, some private insurance companies declined to offer cover to Covid-19 patients.

- The ordinary public health insurance cover did pay part of the Covid-19 treatment costs. The enhanced public health insurance paid for entire Covid-19 hospital bills in public facilities.

- Some private health insurance cover paid partly for care in private hospitals and wholly in public hospitals.

- The private insurance paid for care in public hospitals because of the subsidized costs of care on offer. They similarly paid part of the bill in private hospitals because of high cost of care in the facilities.

Recommendation

- With the continued increase in Covid-19 infections in the country and the region, there is need to have a clear policy on treatment cost for both private and public health care facilities.

- This will help shield the sick from high cost of care and the health insurance companies from exorbitant user fee costs.

- Furthermore, the state should nationalize care for all Covid-19 patients in either public or private facilities to prevent cost discrepancies.

- In addition, both public and private health insurance companies should cover Covid-19 patients seeking care in both public and private health care facilities.