

Executive Summary

This policy brief synthesizes monitoring, evaluation and learning (MEL) data from the African Health Markets for Equity (AHME) programme to make the case for an engendered approach to NHIF reforms. Specifically, the brief explores women's ability to effectively utilize NHIF as dependents of male primary card holders and the active offering of reproductive health services within the national and Linda Mama schemes. The brief concludes that women's effective coverage in the NHIF is limited and provides recommendations to address gender gaps.

Introduction

Universal Health Coverage (UHC) cannot be achieved without attention to equity. Equity is often equated to socioeconomic status with less attention to other social stratifiers. However, research has found that unless policy makers pay explicit attention to gender, efforts to reach UHC may not improve equity and may in fact exacerbate existing gender inequities.¹

Women incur more out-of-pocket expenditure than men. This is, in part, attributed to women's specific health needs related to pregnancy, childbirth, contraception and abortion, amongst others. While biological differences between women and men in health needs and experiences are often recognised within essential benefits packages, there is a tendency to assume that maternal health programmes are an adequate response to addressing differences in health between the sexes.²

Despite higher out-of-pocket expenditure, women are less likely to be included in national health insurance schemes. In many developing countries, national health insurance covers only those working in the formal sector of the economy and their dependents. As such, they are likely to exclude a vast majority of women who work mostly in the informal sector, unless they are covered as dependents of formal sector employees.

Background

The National Hospital Insurance Fund (NHIF) is the main vehicle for UHC in Kenya. The NHIF's core mandate is to provide health insurance cover to all its members and their declared dependents (spouse and children). The NHIF operates two main schemes: the national scheme and the civil servants' scheme. Additional sponsored programmes such as the Health Insurance Subsidy Programme (HISP) and the older persons and persons living with severe disabilities (OLDP) are modelled after the national scheme and were introduced in 2014 and 2015 respectively.³ More recently (2017) the Linda Mama scheme was introduced. The scheme is publicly funded through the Ministry of Health (MoH) and provides a package of antenatal, delivery and post-natal health care services targeting women on the basis of need, and not ability to pay.⁴ The scheme therefore caters for women not covered under the NHIF or other form of insurance.

Coverage in the NHIF remains limited due to the predominance of the informal sector in Kenya. The informal sector in Kenya was estimated to include 83% of Kenya's population in 2017 by the NHIF.⁵ While the NHIF is compulsory for all formal sector workers,⁶ it remains voluntary for the informal sector.⁷ A relatively low-cost product, 'SupaCover', was introduced in 2015 to increase voluntary enrolment of the informal sector. It is currently priced at KSH 500 (US\$ 4.80) per month. Despite these reforms, only 17.7% of the population is estimated to be covered by the NHIF.⁸ Out of 2.9 million members from the informal sector, only 801,634 members were active or current in payment as at 30th June 2017, which represents a retention rate of 27%.⁹

Methods

The AHME programme aimed to increase access to quality private healthcare for poor populations. It concluded in March 2019. The AHME partners included Marie Stopes International (MSI), Marie Stopes Kenya (MSK), Population Services Kenya (PSK), Population Services International, Marie Stopes Ghana, and the PharmAccess Foundation. Funding for AHME was provided by the Bill and Melinda Gates Foundation and the UK Department for International Development. A robust learning agenda underpinned the programme.

The policy brief synthesizes findings from AHME monitoring, evaluation and learning (MEL). Learning was curated by AHME and entailed series of learning briefs and other knowledge products. These were based upon analysis of monitoring data as well as qualitative research. The programme also benefited from an external qualitative and impact evaluation, led by the University of California San Francisco and the University of California Berkley respectively. Specifically, this policy brief draws upon analysis from the qualitative evaluation. It further incorporates relevant learnings from the AHME partners and draws upon available data from desk review and the NHIF reforms committee. As part of the qualitative evaluation, semi-structured interviews were conducted with women at private clinics in Kenya. Eighty-six women were interviewed over three years in 2013, 2017, and 2018. The focus of these interviews was to better understand women's health seeking behaviors, and their experience registering with and using NHIF.

Finding 1: Maternity services are the dominant focus of women's health within the NHIF. Other services, such as family planning, are included in the package, but are not widely available in practice.

As learned from AHME, the inclusion of family planning within the NHIF national scheme is not well understood by providers or NHIF members. Permanent methods, namely tubal ligation and vasectomy are included as in-patient services paid on a fixed fee-for-service and only under the Civil Servants scheme. All other methods, including long-acting reversible contraception (LARC), such as implants and IUCD, are included in the out-patient national scheme, paid through capitation. While capitation was selected as the preferred means of provider payment 'to induce positive incentives in the health delivery system',¹⁰ this may not be the case for family planning. Capitation induces providers to offer cheaper, easier to administer methods, over LARC methods that require more time, skills and consumables. Further, findings from the AHME qualitative evaluation indicate that providers often misunderstand capitation and mistakenly charge patients out of pocket for services that should be covered. While capitation is a cost containment strategy, learning from AHME suggests that contraception may be ill-suited to capitation financing.

Respondent: The government gives us so little money. It's three hundred per head per quarter. That means a patient is only given a hundred shillings in a month. In a year it's one thousand two hundred.

Interviewer: So what do you do if somebody came and maybe spend like seven hundred, and you are allowed not to take more than three hundred per quarter? What do you do?

Respondent: Sometimes if the balance is too big, we force them to pay.

(Private provider, Nyanza)

As learned from AHME, there is limited understanding of the inclusion of post-partum family planning by providers and women. While post-partum family planning is included as part of post-natal care (PNC) the reimbursement rate for each PNC visit is flat and does not reflect the cost of offering this service. Linda Mama is recognised in Kenya's FP2020 "Actions for Acceleration" as an immediate opportunity to improve access to post-partum family planning. However, without a differential reimbursement for this service, it is unlikely to be pro-actively offered to women by providers.

Finding 2: Women reported not using the NHIF despite being covered as they did not have access to the card.

The AHME impact evaluation found that one in four NHIF members do not use their health insurance. The AHME qualitative evaluation has established that this is partly due to the husband being the principal cardholder. As found in the qualitative evaluation, many women do not have access to the card and may not know the card number. This may be associated with separation of family units, with husbands living in another location due to economic or seasonal migration.

Interviewer: And which hospital did you choose?

Respondent: Here I have not chosen, eeh because that time I was in Mombasa. So that card itself is with...with my husband, eeh.

Interviewer: So, you didn't use it?

Respondent: I have never used it again apart from that time when I was admitted [in Mombasa].

(Client at a private clinic, Embu County)

Finding 3: Women are not always able to register for NHIF without the presence of their husbands.

Through AHME, the MSK and PSK social franchises supported NHIF and Linda Mama public education. This sometimes entailed NHIF branch offices, social franchise providers and community mobilisers doing NHIF 'SupaCover' membership drives, as part of outreach and event days. From AHME learning, it was found that in some regions, men are considered 'by default' the principle member for the NHIF. This was found to stall registration if they were not present when registration events took place.

Conclusions & Recommendation

NHIF reforms are intended to position the scheme as the vehicle for achieving UHC in Kenya. For this to be truly universal, gendered inequities in service access, the disproportionate barrier that out-of-pocket expenditure creates for women and the specific reproductive health needs of women and adolescent girls need to be *effectively* included. We submit the following recommendations for consideration by the NHIF reforms committee.

1. Expand the benefit package for reproductive health: We request that, aligned with the goals of UHC in Kenya, the NHIF expand and clarify the offer of family planning benefits as part of the national scheme, and that the MoH and NHIF work towards integration of post-partum family planning services within both the national scheme maternity cover and Linda Mama. Numerous studies have demonstrated that effective spending on quality family planning services represents a direct cost-savings to the health sector, especially for pregnancy-related care. We commit that these cost-benefits should be similarly monitored in Kenya.

Proposal for family planning services:

- **Linda Mama:** Increase provider reimbursement for one post-natal care (PNC) visit to Ksh 500 to reflect the cost of delivering quality post-partum family planning
- **NHIF national scheme:** Introduce a provider reimbursement to Ksh 500 for LARCs to reflect the additional counselling, clinical competency and consumables required for these services.
- **Provision of permanent methods** should be allowed under the national scheme as part of the outpatient contract.
- We propose that the **current reimbursement rates for permanent methods** be lowered so that it is affordable for the NHIF to offer this through the national scheme and to better reflect actual costs.

2. Issue NHIF membership cards to all adults in a household: We request that NHIF membership cards be issued to all adults within a household, as is done with other insurances. We also submit that women should be recognised as household heads alongside their husbands. They should be able to register their family without the presence of the male head of household.

References

1. Witter, Sophie, Veloshnee Govender, TK Sundari Ravindran, and Robert Yates. "Minding the Gaps: Health Financing, Universal Health Coverage and Gender." *Health Policy and Planning* 32, no. suppl_5 (December 1, 2017): v4–12. <https://doi.org/10.1093/heapol/czx063>.
2. WHO, 2010. Gender, women and primary health care renewal: a discussion paper. WHO: Geneva.
3. The HISP pilot ended in 2017.
4. Detailed guidance on specific benefits under these packages is available on the NHIF website: <http://www.nhif.or.ke/healthinsurance/lindamamaServices>.
5. NHIF, 2017. Expanding Social Health Insurance Coverage Among the Informal Sector Population: Strategic Plan 2016-2020, NHIF, Nairobi, Kenya.
6. Government of Kenya. Sessional Paper No. 7 of 2012 on the Policy on Universal Health Care Coverage in Kenya. Nairobi, Kenya: Ministry of Medical Services.
7. The 1998 Amendment of the NHIF Act, requires that all Kenyans have health insurance (i.e. it is mandatory for everyone).
8. Barasa, E, 2019. NHIF presentation to the Bill and Melinda Gates Foundation grantee meeting (April 2019).
9. Barasa, E, 2019. NHIF presentation to the Bill and Melinda Gates Foundation grantee meeting (April 2019).
10. Government of Kenya. Sessional Paper No. 7 of 2012 on the Policy on Universal Health Care Coverage in Kenya. Nairobi, Kenya: Ministry of Medical Services.