

Level of Public Participation in Social Health Insurance Policy Formulation in North Rift, Kenya

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Abstract

In an effort to address the crises of health care financing, the Kenya Government has proposed the National Social Health Insurance Fund, where no payments are to be made by users at the point of being attended when ill but users will have to make regular prescribed mandatory contributions based on their incomes. However, it is unclear if these proposals are owned and have support of all key stakeholders since smooth implementation heavily depends on their participation at formulation hence their awareness, understanding and acceptance for implementation. The objective of the study, on which this paper is based, was to determine the level of participation of Kenyans in the formulation of the Social Health Insurance scheme. This study was a cross-sectional descriptive survey carried out in a sample of health facilities in the North Rift Valley region and at the Ministry of Health and National Hospital Insurance Fund headquarters. The respondents included patients/their visitors/caretakers (218), health facility staff (72), provincial administrators (15) and key informants (10). Data were collected using structured interview schedules and questionnaires with open and closed-ended questions. Purposive and stratified sampling methods were used to arrive at the facilities to be studied and a select key informants, systematic sampling helped arrive at the wards to be included at the national hospital, visitors interviewed at the gates were consecutively sampled while simple random sampling was used to get the patients to be interviewed at the wards; giving a total of 313 respondents. Data collected was analyzed by use of frequencies, percentages, graphical comparisons and inferential statistics of one sample student's t-test for proportions. The findings revealed poor participation levels of below twenty percent (20%) of all categories of respondents. The formulation of this policy has had insufficient stakeholder participation among all respondents. It is recommended that the Ministry of Health should make deliberate efforts to enlist the participation of all stakeholders in formulation of the National Social Health Insurance Fund. The study informs further research on participation of the public in formulation of other public policies as it has been argued that absence of this has led to failure to have support from the public who are uninvolved at formulation. For other readers, this would serve as useful information in informing them as to the importance of stakeholder participation in formulation of any plans in which these stakeholders have a key role to play.

Keywords: public participation, social health insurance policy formulation, north, rift, Kenya

INTRODUCTION

It has been noted that within populations of the same country there are significant differences in health outcomes and morbidity status that are linked to socio-economic inequalities (Bobak *et al.*, as cited in Kutzin, 2003). This is worse when viewed on a continental level. And this problem is unfortunately very prevalent: a survey done in 1987 by the World Bank in 33 sub-Saharan African countries has shown that only seven have health insurance systems, with coverage of the total population ranging from 0.001% in Ethiopia to 11.4% in Kenya (where only civil servants and a few other formal sector employees enjoy this benefit). The rest are excluded. Unfortunately, the excluded command little political support/clout (Dror & Jacquier, 2005).

The foregoing calls for full involvement and inclusion of people's views in whatever decisions are made concerning them. Yet, in most African countries, policy-making is the work of technocrats, who design policies not necessarily to benefit the

wider society, but rather to ensure their continuity in power (Oyugi & Kibua, 2004). The policy-making process is cyclical and largely iterative. Its cyclical nature implies that the first phase of the cycle is subject to change as more information is realized concerning problem definition. The problems of making choices, entrusting the policy process to a small policy aristocracy, underdeveloped analytical capacity, lack of implementation capacity, political instability that has characterized most African governments and deliberate disregard of the stakeholders in the process, all limit the role research plays in informing the policy process (Oyugi & Kibua, 2004). The issue of stakeholder involvement is of particular interest to this paper.

This paper specifically looks at the Kenyan situation where SHI has been in practice through the National Hospital Insurance Fund, which was formed in 1966. What has not been in place is universality of coverage. Indeed, the NHIF dictum "from each according to his ability and to each according to his

need” is clearly a SHI-rooted one, with emphasis on community spirit of solidarity. The main objective of the proposed NSHIF is to facilitate provision of accessible, affordable and quality health care services to all its members irrespective of their age, economic or social status (Republic of Kenya, 2005). This is vital as Kimani *et al.* (2004) show, that 39.5% of rural Kenyans who cannot use medical care while sick are unable due to it being too expensive while the urban equivalent is 43.8%. The health sector reforms that have hitherto taken place (including introduction of NHIF, free health services, cost sharing, exemptions and waivers) have all aimed largely at addressing affordability and access to health care services (IPAR, 2005). There has, however, been no clear documented effort by the Government, even in 1966 when introducing NHIF, to ensure sufficient public awareness, understanding and participation in NHIF formulation and implementation.

The draft NSHIF bill proposes that the government, through NSHIF and general taxation, carries 75% of the national health expenditure burden while the private health insurance carries 25% (Republic of Kenya, 2005). However, it will be compulsory for every Kenyan and every permanent resident to become a member through enrolment and payment of a subscription either monthly or annually, as may be deemed convenient to different socio-economic groups. Subscriptions for the poor will be paid for with funds from the government and other sources (Kimani *et al.*, 2004). Those in the formal sector will pay subscriptions at a proposed rate of 2.9% of their salaries through the payroll, with the employers matching the contributions of employees while collection points will be identified for those in the informal sector with heavy reliance on organized groups such as co-operative societies, *matatu* (commuter vehicles) owners’ associations and *jua kali* (informal) artisans organizations (Kimani *et al.*, 2004). Informal sector employees are to be charged Ksh400 annually. The author wondered how closely the formulators of the proposed NSHIF scheme would work with the aforementioned groups and other groups in the informal sector before arriving at the proposals.

This is especially important, bearing in mind that the World Bank’s Agenda for Reform linked the successful introduction of user fees in developing countries to widespread popular participation (Bogg *et al.*, 1996). This paper seeks to establish how far popular participation has been taken care of by the formulators of NSHIF.

PROBLEM STATEMENT

Kenya, like many developing countries, grapples with health care financing crises, made worse by the rising disease burden compounded by the HIV/AIDS.

Achieving of Millennium Development Goals numbers four, five and six which address health concerns is dependent on solutions to health care financing. In an effort to address this challenge, the Government has proposed the National Social Health Insurance Fund (NSHIF).

The success of this requires the input and support of all key stakeholders and its smooth implementation depends on stakeholder participation at formulation. Although some research has been done around the subject of participation, it is uncertain if the proposals in NSHIF are owned and have support of all key stakeholders.

LIMITATIONS OF THE STUDY

The geographical area was the North Rift Valley region of Kenya where selected health facilities were studied. The study was therefore limited to Kapsabet and Kabarnet District hospitals, Eldoret, Medihealth and Elgon View private hospitals and Moi Teaching & Referral Hospital. The study covered patients, staff and visitors who came to the above selected health facilities at the time. Again, key informants from the NHIF headquarters, Ministry of Health headquarters and provincial administration were sampled. The study sought to assess the level of participation of Kenyans for SHI; right from the policy formulation stage. Literature specific to public participation in Health Policy Formulation in Kenya and elsewhere was very rare both prior to carrying out of data collection and, even after collecting data and analyzing it, there was still a dearth of literature on related studies which one would compare the study’s findings to. Moreover, the socio-demographic characteristics of the sample were not applied to the study findings.

MATERIALS AND METHODS

The study was carried out in selected facilities in the North Rift Valley region of Kenya; specifically at Moi Teaching and Referral Hospital, Kapsabet and Kabarnet district hospitals and Elgon View, Eldoret and Medihealth private hospitals in Eldoret town. A number of leaders in the Provincial Administration in Baringo, Nandi North and Uasin-Gishu Districts were included. The participants were exiting patients, those in the wards and their care takers, waiting visitors and the author focused on capturing farmers, business people and pastoralists in the sample. This first sample set represented members of the general public and it was a single set. Health workers were targeted as both consumers/contributors and partial implementers of the proposed scheme. Provincial administrators were targeted as leaders at the grassroots and who are the main representation of the Kenya Government at that level. They were visited at their places of work. Key informants were Ministry of Health and NHIF staff who had actively participated in the formulation of the proposed

NSHIF. They were also visited at their work-place. All these categories of respondents were interviewed. The study design was a cross-sectional descriptive survey conducted among stakeholders at various health facilities and in some offices. This design was appropriate considering the amount of time available and also the nature of the problem to be studied. Interviews with respondents were conducted within a span of two and a half months.

Purposive and stratified sampling methods were used to determine the facilities to be studied and they were identified as a national referral hospital, the Moi Teaching and Referral Hospital, two district hospitals, that is, Kapsabet and Kabarnet district hospitals and three private hospitals, namely Elgon View, Mediheal and Eldoret hospitals. Wards at the referral facility were systematically sampled, that is, out of wards 1 to 10, only the odd number wards were sampled. The first number of ward (7) to be sampled was randomly sampled and from it, every second ward was sampled. Here, the patients to be interviewed were randomly sampled at the wards where the bed numbers were written on pieces of paper and those beds randomly picked had their occupants interviewed. In cases where the numbers targeted per ward were not attained, this was repeated on a different day and time till the numbers were achieved. At the district hospitals, the wards were consecutively sampled but the patients in the wards were randomly sampled to achieve the required numbers. At the referral and district hospitals gates, consecutive sampling was used and every subsequent visitor consenting to participate was interviewed till when the gates would be opened. The visitors and patients represented members of the general public.

The health workers were stratified into three cadres, that is, low-level or operational/transactional, middle-level or tactical and top-level or strategic. At the Referral Hospital, job groups were used to arrive at these categories. Each job group had a ratio assigned to it. Among the cadres, based on a list of staff provided, simple random sampling was then used to arrive at the specific ones to be interviewed. At the district and private hospitals, heads of the facilities and heads of departments were purposively sampled while the rest of the staff were sampled randomly.

Key informants at the Ministry of Health and NHIF headquarters were purposively sampled to get ten of only those who had participated in the SHI policy formulation process. The Provincial Administration officials were stratified in two strata of chiefs and assistant chiefs who were then randomly sampled to assure two chiefs and three assistants for each of the three districts. They were assumed to have had a role in promoting the proposed fund. Data was collected using interviews and questionnaires. SPSS computer software was used to enter and analyse data.

Frequencies were run and cross-tabulations done to look for trends, differences and relationships among variables. Descriptive statistics included proportions, percentages and frequency tables for comparison. Inferential statistics were employed where student's t-test for proportions was done at 5% significance level. Data presentation was in linear text, tables and bar graphs.

RESULTS AND DISCUSSION

Public Participation in NSHIF Policy Development

To obtain data on the public participation in the process of formulating the SHI policy, key informants were interviewed. According to them, the Ministry of Health made the policy then sent it to NHIF board for adoption; a task force that included members of parliament was then appointed. They reported after visiting various countries, then there was drafting of the bill and presenting it to parliament.

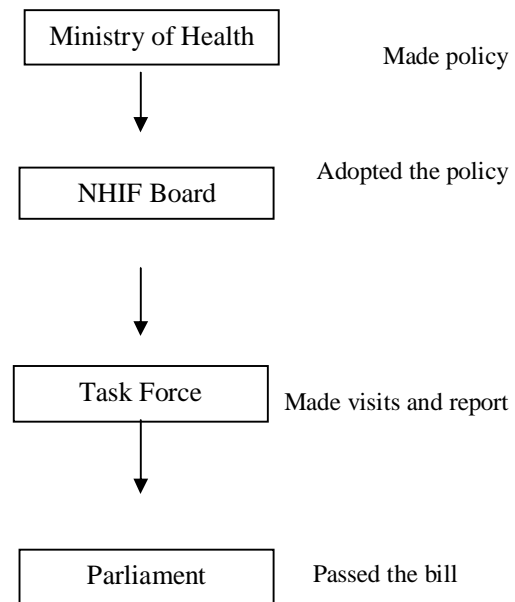


Figure 1: Steps followed in formulation of SHI - According to Key Informants

NSHIF was therefore formulated by the MOH, and given to NHIF for implementation. A strategy paper was drafted, resulting to the NSHIF bill-which went through the normal process of enacting a bill in Kenya. According to these informants, the stakeholders who participated in the formulation of the scheme were identified through the media and through bodies represented on the board/groups representing various interests and letters written to them to attend workshops.

However, all the 218 respondents among patients/visitors/caretakers said neither themselves nor family members had their input sought by the

formulators of this policy. Over 80% of them (175) said the public was left out while the scheme was being formulated.

In addition, only 2.8% (2) of the 72 health-care providers said their views were sought when this scheme was formulated. The rest responded to the contrary. A similar percentage was recorded for those who responded to the question asking if their workmates had their views sought while 99% (71) of respondents in this category said the formulators of this policy just wanted to involve them at the stage of its implementation and not earlier. While 72% (52) of health-care providers said international organizations did not participate in formulating this scheme, 87% (63) of them said the public was left out in its formulation and 72% (52) opined that the media was excluded. A reasonable 62% (45) of them were of the view that the state participated in this scheme's formulation while 82% (59) of the health-care providers said interest groups were left out.

Of the provincial administrators interviewed on this, 93.3% (14) of them felt there were other people/groups of people who should have been contacted for views at the formulation of this scheme, but were not contacted.

Unlike in the case of developed countries, stakeholder involvement in policy formulation is an issue of concern in most developing countries. As it came out in the case of NSHIF, on public participation, all the 218 respondents in the category of patients/visitors/care-takers said no one sought their views on this scheme. This reflects the level to which government policies exclude public participation, especially in their initial stages leading to their being misunderstood and sometimes misinformed resistance. As seen in the case of Russia, at the formulation of obligatory medical insurance, there were no deliberate, clear steps made to get public views. This scheme was to be later looked at by the public as 'worthless scraps of paper' (Twigg, 1999).

More notable was that 93% of 72 health-care providers interviewed had no one seeking their views and a similar percentage did not know of any colleague who had their views sought at formulation stage of this scheme. These kinds of figures are reflective of the indifference displayed towards the scheme by its possible beneficiaries/implementers due to lack of participation. Most of the provincial administrators interviewed were of the view that there are groups of people whose views should have been sought but were left out while formulating the NSHIF. Some of those whom they felt should have participated included themselves (provincial administrators), the physically disabled, the informally employed, that is, farmers and

businessmen, teachers, civil servants, those in the judiciary, social workers and the general public. As in the case of the Republic of Korea, policy formulation initially excluded public participation leading to a lot of resistance (Kwon & Reich, 2005). This exclusion is also in direct contravention of the provisions of the Hall model for sound policy formulation (Walt, 1994).

When asked how much time the public were given to give their views on this scheme, the key informants did not seem to read from the same script with some of them saying it was 6 months; some that it was 8 months; others that it was 12 months and yet some did not have an answer to this. Considering that these were people who had actually participated in the process of formulating this scheme, this was seen as an indication that this process did not put much importance on public participation. As seen in the South Korea case, this scenario could compromise preparedness of stakeholders for participation in implementation and hence hamper effectiveness (Kwon & Reich, 2005).

A study on the United Kingdom's NHS (BMJ No. 7239) underscore the importance of involving locals in creating awareness and promoting preparedness of stakeholders for implementation of SHI if it is to have a good chance of success. In this study, there was unanimity of views and clear indications that in the case of NSHIF, participation both of the public and key stakeholders was not given the necessary importance.

CONCLUSION AND RECOMMENDATIONS

It is clear that stakeholder participation in the Social Health Insurance Policy formulation in Kenya is very low among all categories of people, namely patients/visitors/caretakers, health care providers and provincial administrators. The conclusion was that the formulation of this policy had insufficient public participation. According to the informants, the stakeholders who participated in the formulation of the scheme were identified through the media and through bodies represented on the board/groups representing various interests and letters written to them to attend workshops.

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The Ministry of Health should, therefore, make deliberate efforts to enlist the active participation of all stakeholders in formulation of NSHIF to enhance its success at implementation. A situation such as where NHIF staff as well as health care providers felt left out in such a key policy should be addressed and avoided.

REFERENCES

Bogg, L., Hengjin, D., Keli, W., Wenwei, C., & Diwan, V. (1996). *The Cost of Coverage of Rural Health Insurance in China*. Health Policy and Planning, London School of Hygiene & Tropical Medicine, Oxford University Press.

Dror, D., & Jacquier, C. (2005). *Micro-Insurance: Extending Health Insurance to the Excluded*. Geneva: Social Security Dept., ILO Planning, Development & Development Branch.

IPAR (2005). *Social Health Insurance Scheme for All Kenyans: Opportunities & Sustainability Potential*. IPAR.

Kimani, N. D., Muthaka, D. I., & Manda, D. K. (2004). *Health Care Financing Through Health Insurance in Kenya: The shift to a National Social Health Insurance Fund*. KIPPRA Discussion paper No. 42.

Kutzin, J. (2003). *Report of a Regional Consultation & Technical Workshop: Health Systems Performance Assessment*. WHO.

Kwon, S., & Reich, M. (2005). *Changing Health Policy Process: Politics of Health Care Reform in Korea*. *Journal of Health Politics, Policy and Law*, 30(6): 1003-1026.

Oyugi, L. N., & Kibua, T. N. (2004). *Policy Research and Policy Analysis: An Exploration of Principles and Practice in Kenya*. IPAR Discussion Paper No. 043.

Republic of Kenya (2005). *National Health Sector Strategic Plan (NHSSP II: 2005 - 2010)*. Nairobi: Government Printers.

Twigg, L. J. (1999). *Obligatory Medical Insurance in Russia: Participants' Perspective*. *Journal of Social Sciences and Medicine*, 49.

Walt, G. (1994). *Health Policy: An Introduction to Process and Power*. London: Zed.