Policy Brief on National Hospital Insurance Fund (NHIF)

Key Policy Considerations for Promoting Livelihoods and Inclusion of Vulnerable Women Domestic Workers and Women Small Scale Traders from Slums in Nairobi in NHIF

Policy Brief Outline:

1. Executive Summary: Key Messages: 3-5 key points (in a box)
2. Introduction and issues identified
3. Content (Body): addressing key messages (Simple Figures and Diagrams and Photographs and quotes)
4. Numbered recommendations
5. Key References

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1.0 Executive Summary

This policy brief examines the efficacy of health related social security programmes in particular NHIF in protecting and enhancing the rights of women domestic workers and small-scale traders in slums. It was undertaken in slums of Mukuru, Kibera, Korogocho, Mathare and Kawangware in Nairobi and relied heavily on desk review, key informant interviews and focus group discussions with randomly and purposefully selected women including case collection.

The policy brief i) analyses the NHIF health scheme in its current forms outlining the potential benefits to the target women ii) offers analysis of the challenges of the scheme and areas that may derail the target women from enrolling iii) explore flexible remittance methods like piecemeal payment of monthly contributions, engaging community based payment agents and phone technology payments for NHIF and iv) recommend options/packages that would if adopted make the scheme responsive to the target women and effective strategies that could be used to encourage the women to register with the NHIF scheme.

The policy recommendations are predominantly anchored in i) Article 21 of the Constitution which commits the State to working towards the gradual realization of the social and economic rights and binds the State "to observe, respect, protect, promote, and fulfil the rights and fundamental freedoms in the Bill of Right" and CoK 2010 recognizes the right to health. Article 43 (1) States that 'Every person has the right— (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

Key findings show that there are a number of cases of women domestic workers and women small scale traders accessing health services through NHIF support for example in Mathare sums 3 out of eight (37.5%) women interviewed had enrolled for NHIF, in Kibera and against the odds of quite incentivized plans 2 out of 6 (33%) had enrolled while in Mukuru only respondent representing 16% was a member of NHIF. Information generated indicates great potential to expand coverage with appropriate programming and publicity across the five slums. The greatest challenge is and continues to be male dominance and control over health and health seeking behaviours.

This report concludes that there are fundamentally huge opportunities for structuring NHIF programmes to promote wider coverage through increased membership by vulnerable groups while conferring better range of benefits. The need to raise the level of awareness on NHIF to the target group through aggressive marketing and stakeholder engagements and promoting greater participation of women small traders and domestic women workers among other vulnerable groups is the entry point.

The report recommends reforms in the manner in which social security in health matters is coordinated to promote inclusions of vulnerable groups who have hitherto depended on less concrete social security measures in health provision. In-deed re-focusing the NHIF as a fully-fledged comprehensive national health insurance scheme, which covers all Kenyans, and to which those who can afford it must contribute is important. Other recommendations that stand out include:

1) Ensure adequacy of benefits under NHIF and other medical schemes and their accessibility by geography and demographic groups.

2) NHIF to work with County Government of Nairobi to increase the scope of coverage of health coverage in slums through in the interim promoting accreditation of private hospital and in the medium term establishing public hospital facilities in the slums.

3) Design programme for NHIF should take into account the greater need for women control over their health and their children who naturally are quite proximate to them. The design should allow access to benefits in separation, continuation of payment from either of the spouse and eliminate bottlenecks to accessing the services.

4) NHIF should prioritize standardizing their services across and making its membership aware of the range of services offered.

5) National Social Protection Council coordinate Social security programmes in health with a view to create more synergy, complementarity and incentives for expanded range of social security services in health sector.

2.0 Introduction

2.1 Purpose of the task

This policy brief examines the efficacy of NHIF in protecting and enhancing the rights of two predominantly vulnerable groups in urban slums. In Particular it examines the extent to which NHIF realizes the right to health for women domestic workers and women small-scale traders in slums of Mukuru, Kibera, Korogocho, Mathare and Kawangware in Nairobi.

While offering the preferred policy and practice options, specifically the policy brief is structured to:

1. Analysis of the NHIF health scheme in its current forms outlining the potential benefits to the target women.
2. Detailed analysis of the challenges of the scheme and areas that may derail the target women from enrolling.
3. Explore flexible remittance methods like piecemeal payment of monthly contributions, engaging community based payment agents and phone technology payments for NHIF.
4. Recommend options/packages that would if adopted make the scheme responsive to the target women and effective strategies that could be used to encourage the women to register with the NHIF scheme.

2.2 Policy and Legal Context for the Issues

Article 21 of the Constitution commits the State to working towards the gradual realization of the social and economic rights and binds the State "to observe, respect, protect, promote, and fulfil the rights and fundamental freedoms in the Bill of Rights." For this to be achieved, the State is expected to take legislative, policy, and other measures as necessary, including the setting of standards. Constitution of Kenya 2010 and international rights instruments recognize the right to protection against discrimination among other factors age and social class. The right to a dignified life is recognized as right; in fact the essence of human rights is to preserve human dignity.

CoK 2010 recognizes the right to health. Article 43 (1) States that 'Every person has the right— (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; (b) to accessible and adequate housing, and to reasonable standards of sanitation; (c) to be free from hunger, and to have adequate food of acceptable quality; (d) to clean and safe water in adequate quantities'. Whereas item (a) above is explicit on health the other sub items are related to the realization of the right to health. Item 43 (e) is even broader as it guarantees every Kenyan the right to e) to social security. Furthermore emergency medical treatment is guaranteed and basic rights. Article 43 (2) states 'a person shall not be denied emergency medical treatment' and this applies to all medical facilities whether private or public. From the foregoing it is clear that social protection broadly and in specifics promotion of programmes that promote social security and eliminate discrimination in access to health services in well anchored in the law.

2.3 About NHIF

The National Hospital Insurance Fund is the only national health related social scheme with a national coverage. The other social protection programmes are either private in character or run by charitable institutions. The social waiver programmes within hospitals, free maternity services are the other social support services that are being introduced by both National and County Governments.

The Fund is anchored in law, The National Hospital Insurance Fund Act (1998) that establishes the National Health Insurance Fund ('the Fund') and the Fund Management Board and provides for contributions to and the payment of benefits out of the Fund. Progressively the Fund allows contributions to the Fund from both persons who are in salaried employment as well as those whose income is derived from self- employment (Section 15, c) The Fund offers monthly premiums ranging from Kshs.30 to Kshs.320 which could be considered low compared to those of conventional insurance schemes, which are actuarially determined.

2.4 Methodological Approach

The study relied heavily on desk policy and legal reviews, information from key informants and focus group discussions of women domestic workers and small-scale traders randomly and purposefully selected for the purposes of this study. The women were interviewed individually (for case studies) and collectively to inform general perspectives. Further, selected women from the Focus Group Discussions (FGDs) were identified and in-depth interviews undertaken with them. Information generated from these women form basis for the case studies.

3.0 Content and Key Issues (Review of literature)

3.1 Analysis of the NHIF health scheme in its current forms outlining the potential benefits to the target women

Periodic contributions to the Fund are low compared to contributions prescribed under commercial schemes. NHIF has as such been able to work with self-help groups in informal settlements and increase the coverage and this in part explains why some women domestic workers and women small-scale traders had enrolled in the scheme. However NHIF penetration to the urban informal settlements is hampered by poor leadership structure among small-scale women traders and women domestic workers. Priority is given to women co-operative movements because of their formal structure, which makes it easier for NHIF to reach them. In addition the rate of penetration of NHIF in the urban informal settlements is 10% because of few hospitals that cater for medical cover at 100% is only Kenyatta National Hospital (KNH). Secondly, the Nairobi County Government hasn't invested much in the provision of health services in the informal settlements because this isn't a priority according to a key informant of the study. It was curious to note that NHIF gives 5% commission of the total revenue to women group, which has over 500 registered members but does not have sound programming focused on increasing their membership.

Policy Message 1: NHIF is yet to tailor make program to better serve this segment. Whereas general awareness on services offered by NHIF may facilitate greater enrolment it is important for NHIF to work with women domestic workers and small-scale traders in slums to tailor make programme and cover options that are relevant to their context.

Policy Recommendation 1: NHIF to work with County Government of Nairobi to increase the scope of coverage of health coverage in slums through in the interim promoting accreditation of private hospital and in the medium term establishing public hospital facilities in the slums.

There are a number of cases of women domestic workers and women small-scale traders accessing health services through NHIF support. This was widely reported in the focus group discussion and in in-depth case discussion with some of the women. Information generated though incongruent for clear tabulation indicates great potential to expand coverage with appropriate programming and publicity across the five slums. For example in Mathare sums 3 out of eight (37.5%) women interviewed had enrolled for NHIF, in Kibera and against the odds of quite incentivized plans 2 out of 6 (33%) had enrolled while in Mukuru only respondent representing 16% was a member of NHIF. Health costs were quite varied with highest reported at Ksh.5000 but there was a general preference for public hospital and self-medication across the counter. The greatest challenge is and continues to be male dominance and control over health and health seeking behaviours with male controlling the cards in Kibera. This has implications on the space available for women to make health related decisions and generally health seeking behaviours. NHIF doesn't have a tailor-made programme for urban informal settlements and high poverty incidence among members of this segment continue to constrain access with monthly incomes fluctuating between Ksh.2000 and Ksh.5000

Case1: Dorcas from Kibera experienced labor pains in June 2015 and was rushed to KNH (Kenyatta National Hospital) and was admitted. She stayed at the facility for three days incurring a bill of Ksh.17, 000 that was fully paid by NHIF. She paid nothing and she expressed satisfaction with the NHIF services.

Case 2: Jane Adhiambo from Kibera experienced child delivery on 23rd March 2015 and was admitted at KNH for four days accumulating Ksh.15, 000 as expenses. The husband paid Ksh.3000 during admission and NHIF cleared the other balance. NHIF plan helped the women in such emergency situations.

Policy Message 2: Whereas experience of NHIF services in the slums is varied, there is positive feedback for those who have managed to enjoy health covers, as they ought to be enjoyed. This demonstrates that there is a fertile ground for both upscaling this programme with clear and additional value addition features. NHIF should work closely with beneficiaries to address the bottlenecks of their service delivery in these areas

Policy message 3: There is room for greater penetration of NHIF services in the slums. In the spirit of promoting gender inclusions and women control over health and health related decisions, NHIF should invest energies in mobilizing opinion from women who are already organized in women groups.

Policy Recommendation 2: Design programme for NHIF should take into account the greater need for women control over their health and their children who naturally are quite proximate to them. The design should allow access to benefits in separation, continuation of payment from either of the spouse and eliminate bottlenecks to accessing the services.

In part some of the policy messages and recommendations above are reinforced by the case below:

Case 3: Cecilia Wangechi, 33 years separated with her husband. She tried registering for NHIF but could not proceed due to lack of support from the husband. She lost hope in NHIF since she could not get her former husband to fill the papers.

The research team also came across cases of service inconsistencies. In many of the cases services inconsistencies were informed by the nature of contract the health facilities have with NHIF, the range of services available within the facilities and general practice on refereeing patients to seek some services outside contracted facilities.

Case 4: Lilian Atieno from Mathare had chest pains and was admitted at Kenyatta National Hospital (KNH). She was required to take a scan where she was referred to a private clinic where she paid Ksh.5000 as NHIF could not pay for the scan cost. NHIF then paid for a portion of medicine bills as other medicines were bought from chemists referred to by the medical staff.

Case 5: Angeline had a brother who had enrolled for NHIF and was involved in an accident. She was admitted at Guru Nanak where she paid all other bills as NHIF only paid for the bed.

Policy Message 4: Lack of uniform standards of services and surprise costs erode beneficiary confidence, more so among the resource constrained segment of membership

Policy Recommendation 3: NHIF should prioritize standardizing their services across and making its membership aware of the range of services offered.

3.2 Analysis of the challenges of NHIF and areas that may derail the target women from enrolling.

Section 19(2) of the Act imposes a penalty on persons liable to pay a special contribution for not paying on due date to pay 'a penalty equal to five times the amount of the contribution. This penalises the poor, the unemployed and casual labourers and others in the informal sector that do not rely on a regular income to pay their contributions.

Case 6: A family member (Boy), related to Esther Akinyi, had an accident where his leg was pierced by the metals used by the NYS during construction in Kibera. The bill was Ksh. 6000 but NHIF could not pay since it only covered inpatients. "NHIF haitumiki kwa outpatient lazima ulazwe ndio uitumie!" (NHIF is not accessible to the outpatient but only inpatients)

Linked to the penalties is how the communities of beneficiaries perceive other complimenting programmes. Broadly speaking the role of

complimenting social security programmes in health sector is less understood and appreciated by beneficiaries. The other social security measures have in some cases served as a disincentive for enrolment in NHIF

Case 7: Mercy Madedo had an experience where her husband had been paying Ksh. 160 every month for NHIF. This went on until 2015 where they stopped after the NHIF rates were revised. Four months later, by November 2015, she was in labour pains and since she had not paid to the date, she was forced to seek more money to add to be able to use the NHIF card. Since they had no money, they went to Makadara dispensary where she paid Ksh. 20 per day for two days. She delivered and had medical attention and medicine given to her at a total of Ksh. 40.

Policy Message 5: The need for overlapping and complementing state-led social security programmes in health sector cannot be downplayed. Nevertheless there is need for educate Kenyans of all walks to diversify on the range of health security measures

Policy Message 6: The penalties as well as denial of services for non-compliant members does not necessarily motivate compliance rather it pushes clients seek other non-linear options with implications of more dropouts of members already in the scheme.

Policy Recommendation 4: NHIF should review the period for default for vulnerable populations under individual membership in the scheme as well as providing for reasonable period for repayment.

Availability of other programmes that are free in character may impair the growth and penetration of contributory schemes such as NHIF

Case 8: Shining hope for Communities (Shofco) is a local NGO that serves the people of Kibera slums. It focuses on areas key to eliminating poverty including health, water, food security, and capacity building. It has focused on helping people in Kibera slums through provision of free-health services. SHOFCO is supported by CDC (center for disease control) and offers services parallel to those of NHIF. In fact, two members showed their SHOFCO membership cards that they use for accessing free health services. New member get registered and they wait for three days to get their card. A letter is written referring them to hospitals like KNH and Mbagathi for treatments. Both hospitals treat patients with SHOFCO cards as the organization clears all the bills irrespective of the illness. A member with SHOFCO card will cater for all the family members. Cases of specialized treatments are also covered as well as emergencies.

"Hakuna haja ya NHIF kama SHOFCO iko" (There is no need of NHIF if SHOFCO is there) said one member. This case study insinuated that NHIF has no benefits to the Kibera women who opt for free SHOFCO plan especially if their husbands are not under NHIF. All members agreed that sparing Ksh. 500 to save for the NHIF is difficult hence they go for free service providers like SHOFCO.

Policy Message 7: National Social Protection Council has not taken a keen role in coordinating social security/ protection programmes in health sector. Whereas the need for complimentary social protection programmes cannot be downplayed the need for coherence, elimination of inconsistencies and clear policy direction is imperative in achieving social security objectives

Policy Recommendation 5: National Social Protection Council coordinate Social security programmes in health with a view to create more synergy, complementarity and incentives for expanded range of social security services in health sector.

The above policy recommendation is reinforced in the Case of Eastern Dinaries a Non-Governmental Organization that works to promote good health of HIV positive patients. It focuses on helping patients and their families get access to quality healthcare. It was reported that the NGO provides free treatment for all affected patients and it covers treatment of all illnesses. Members felt this was not inclusive as it covered only a section of the slum population.

Even though the right to health is guaranteed by constitution, women domestic workers and small scale trader from slums continue to suffer the burden of trading off their civil and political rights in order to access health services. This seems to be the norm rather than the exception as women leave their National Identity Cards as collateral for the health related debts. There are rising cases of women and their sick children leaving their valuables at the private hospitals to act as debt guarantee for them to pay the medical bill. This trend could potentially implicate realization of other civil and political rights, if it was an election period. Below are some interesting experiences.

Case 9: Khadija Halkana had a sick child and went to a private dispensary at Unit 56 Dispensary in Kawangware where her child incurred a bill of Ksh.850. She had only Ksh. 500 which she paid and the doctor could not allow her to go home without clearing the balance. Khadija offered to leave her National Identify card (ID) as a security. She took one month to get the balance, paid it and collected her ID.

Case 10: Beatrice Mukula took her sick child with diarrhoea to Muteithia Dispensary in Kawangware. She was supposed to pay Ksh. 1000 but she had only Ksh. 500. She left her ID and went home. It took her three months before she went to collect her ID after paying.

Case 3: Annete Frida went to Wema Nursing Home in 2014 where she was diagnosed with high blood pressure. Her medication and lab tests accumulated a bill of Ksh. 6000 but could only manage Ksh. 2000 then. She left her ID, took two months to get the balance to clear the bill.

Policy Messages 8: Access to health should not compromise civil and political rights of women and by extension degrade dignity. Given the nature of casual work that women slum dwellers are involved in and the need to prove their identity to their clientele, the process of leaving IDs at dispensaries compromises women capacity to search for casual jobs and hence ability to improve on their income status.

Policy Recommendation 6: Expand on the scope and availability of social waivers beyond current coverage of public hospital and in line with accessibility of health services to vulnerable populations in slums.

Finally, it will be useful to situate this analysis within a broader context of social protection and environmental rights. In a random 5% sample drawn from the paper-card database of slum based clinic to assess basic characteristics and health complaints of visitors showed that more females with average age ranging from 20.46 to 21.30 years than males with average age ranging from 15.86 to 19.49 years are the visitors of the clinic. The major health complaints and diagnoses in addition to the differences in health complaints and diagnoses by slum show that environmental conditions can have major influences on health status. Therefore, environmental improvements are important in the improvement of health status. A very high prevalence of respiratory complaints and gastrointestinal problems signify that improvements in air pollution reduction, drinking water provision, and waste management in slums can lead to more significant and sustainable improvements in health status than just simple treatment

Policy Message 9: It is possible to types and prevalence of health related complications in slum areas with appropriate investments in social and environmental protection measures.

Policy Recommendation 7: NHIF and National Social Protection Council should work collaboratively including in direct investments in slums, but more fundamentally to influence National and County Governments to prioritize resource allocation to counties to improve social service delivery.

3.3 Explore flexible remittance methods like piecemeal payment of monthly contributions, engaging community based payment agents and phone technology payments for NHIF

The research team identified the best remittance method that is suitable for the target group is MPESA, Co-operative Bank, Equity Bank, cooperative societies, women groups, and micro fiancé institutions. There was nevertheless need for NHIF to roll-out an agency model so as to reach small-scale women traders and women domestic workers and may be with pay-out of small commissions. Beyond the quick commissions paid to these institutions NHIF should re-think the role of youth in both creating awareness and leading in recruitment process in slum areas and given their reach, penetration and innovative programmes that they run in these areas. After all, the youths are both potential and future members of the NHIF scheme

Recommendation: Invest strategically in not only mobilizing women but also investing for increased share of beneficiaries in the future

4.0 Conclusions and Recommendations

This report concludes that there are fundamentally huge opportunities for structuring NHIF programmes to promote wider coverage through increased membership by vulnerable groups while conferring better range of benefits. The need to raise the level of awareness on NHIF to the target group through aggressive marketing and stakeholder engagements and promoting greater participation of women small traders and domestic women workers among other vulnerable groups is the entry point.

The report recommends reforms in the manner in which social security in health matters is coordinated to promote inclusions of vulnerable groups who have hitherto depended on less concrete social security measures in health provision. In-deed re-focusing the NHIF as a fully-fledged comprehensive national health insurance scheme, which covers all Kenyans, and to which those who can afford it must contribute is important. Other recommendations that stand out include:

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5.0 References

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National Hospital Insurance Fund Act

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