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## 'Hospitals Are Medicine and More....' An Assessment of Subsidised Health Insurance Beneficiaries' Experience in Western Kenya

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Promoters,  
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Financial protection remains an important hurdle to overcome if Universal Health Coverage is to be achieved in sub-Saharan Africa. An innovative model of subsidised health insurance to vulnerable households was implemented in one level four and two primary health care facilities in Western Kenya. The project aimed to determine whether reduced insurance costs, socioeconomic empowerment, and the availability of drugs would improve patients' experience and encourage them to co-pay. This was a secondary analysis of a mixed methods study with a cross-sectional household survey consisting of 18 semi-structured interviews conducted with NHIF subsidy program beneficiaries. Most beneficiaries accessed care as a result of the program. However, challenges of stockouts and inadequate healthcare workers persisted and discouraged some of them from going to the participating facilities. Community Health Promoters were very instrumental in enlightening the community on the cover and getting the sick beneficiaries to go to the hospital. The socioeconomic empowerment programme was beneficial but was mostly long-term and required financial input from the community members before they could sell the poultry or agricultural produce. Most community members were willing to pay after receiving health services using the cover. The study recommends contextualisation of socioeconomic empowerment programs, which are very important in enabling families to generate income to pay for health insurance. Additionally, improving the service delivery experience is important by reducing stockouts, having sufficient healthcare workers, and eliminating facility-related delays, which would improve the confidence of communities in public health facilities, thus retaining health insurance.

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**INTRODUCTION**

Universal health coverage (UHC), enshrined in the United Nations Sustainable Development Goals, aims to ensure that all individuals have access to quality health services without suffering financial hardship. However, there has not been an agreed workable strategy in Sub-Saharan Africa (SSA) for financing healthcare that leads to UHC. SSA requires innovative health financing strategies which must underpin financial protection (Ifeagwu et al., 2021).

One of such innovations was implemented in Western Kenya. Households for which they were unable to pay their health insurance premiums were paid. They were then required to contribute 50% of the premium from the second year. Enrolled principal members were organised in socioeconomic empowerment groups and introduced to agricultural programs. The aim was to enable them to cultivate and sell their produce so that they pay NHIF premiums.

Three facilities participated in the project: one level four being the hub, one level three, and one level two. This project was designed in line with the newly launched government Primary Health Care (PHC) strategy of Primary Care Networks. An end-line survey was then conducted to understand the beneficiary experience in the program that covered 2050 households and 8519 individuals. An initial quantitative analysis of the project data established that an estimated 65.9% of individuals fell below the poverty line after Out-of-Pocket expenditure (Maritim, Koon, Kimaina, Lagat, Riungu, Laktabai & Goudge, 2023)

This paper is a secondary analysis of the qualitative interviews to understand beneficiary experience both at the facility level and with the socioeconomic empowerment activities. The interventions in the projects included NHIF subsidy, involvement of the beneficiaries in a socioeconomic empowerment program, and a drug store called the Revolving Fund Pharmacy (RFP). The RFP is AMPATH-owned, procures drugs from approved government suppliers, and operates in all the facilities participating in the project. This was created with an operational agreement between Busia County and AMPATH. The RFP was necessary to ensure an uninterrupted supply of drugs to the beneficiaries.

**Objectives**

- To determine whether beneficiaries of subsidised health insurance were able to access care.
- To establish the challenges faced by beneficiaries of subsidised health insurance in accessing care.
- To understand the role of socioeconomic empowerment in community members payment of health insurance

**Research Questions**

- Were people with insurance coverage able to access services in public health facilities?
- What are the challenges faced by people with insurance coverage in public health facilities?
- What is the importance of socioeconomic empowerment on retention in health insurance schemes?

## Justification of the Study

Busia is among the ten poorest Counties in Kenya, with 48.6% of the population living below the poverty line. The County has a high food poverty proportion of 59.5% (The Kenya Poverty Report, 2021). Only 6.1% of the population has insurance coverage (Maritim, et al., 2023), while the County ranks 6th in Out-of-Pocket expenditure amongst the 47 County Governments (Commission on Revenue Allocation, 2022). Going by these statistics, AMPATH has implemented several interventions in Busia County aiming towards the attainment of UHC, focusing on financial protection. This project supported UHC in Busia County by piloting insurance coverage in a community and working with hospitals to improve service delivery (Mercer et al., 2018). At the conclusion of the project, a beneficiary survey was done to understand their perceptions on the utilisation of the cover. This information will be important in advising the national and County Governments in implementing the UHC agenda.

## METHODS

This was a secondary analysis of a mixed methods study with a cross-sectional household survey consisting of 18 semi-structured interviews conducted with NHIF subsidy program beneficiaries in Western Kenya. The study was embedded in a larger household survey conducted between August and October 2021 by investigators at the Academic Model Providing Access to Healthcare (AMPATH), an academic collaboration between Moi University, Moi Teaching and Referral Hospital, and a consortium of universities led by Indiana University. The purpose of the survey was to understand beneficiaries' experience with health facilities while utilising the cover. A four-member research team developed a new Code Structure and analysed the data thematically using Dedoose 9.0.46.

## Study Setting

Data was collected from 18 households in the Bunyala sub-county in Busia County, Kenya. Bunyala is located on the western Kenyan border

with Uganda, where AMPATH implements a population health program.

## RESULTS

More than 90% of the beneficiaries of the NHIF subsidy program were able to access health services at the designated facilities, as shown in *Figure 1*. However, there were so many challenges while accessing services, which were mostly a lack of drugs and delays in service delivery, especially at the hub facility. More than half of the beneficiaries participated in some form of socioeconomic empowerment. An estimated 40% of the beneficiaries were making partial contributions to their health insurance coverage. Participants who got treated using the cover earlier on in the program showed higher levels of commitment to payment. The Revolving Fund Pharmacy provided drugs for all the patients under the scheme.

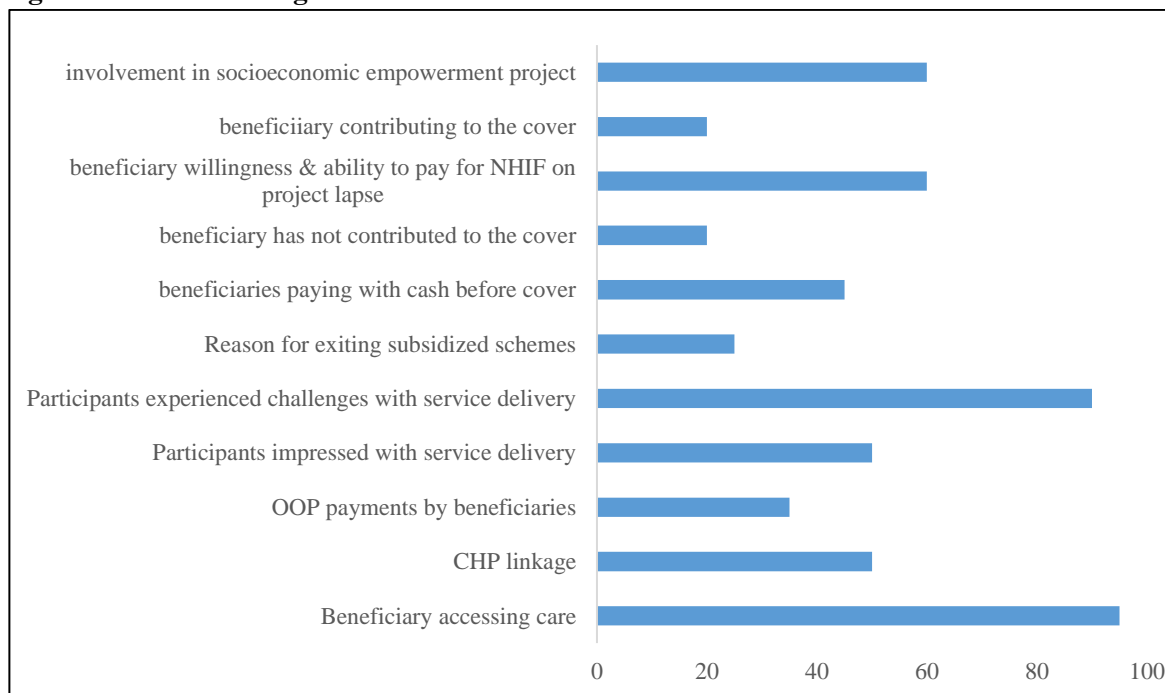
## Access to Care

Most beneficiaries and their families were able to access care at their respective facilities. The level 2 facility received more patients compared to the hub, and this was attributed to the availability of commodities and client satisfaction with service delivery.

*"The first time my son was sick, and they said that this card also serves outpatient. True to word, he came and was treated. The second time, my wife came and was admitted, and it helped her...."*

*"I usually do not fall sick or look for treatment here and there, no. Even my family. So, when I became sick, I underwent an operation, and that is when the programme helped me."*

The total amount of money paid to the three facilities by NHIF was estimated at Ksh. 1,206 648, while the average cost per visit was Ksh. 441

**Figure 1: Thematic weights statistics chart.**

### CHP Involvement in Community Social Health Insurance Sensitization

As the first level of care, CHPs were very instrumental in reaching the households to inform them of being beneficiaries of the subsidy programme. Through the CHP programme, one of the beneficiaries accessed oncology treatment using insurance coverage. This is a further confirmation that CHPs are critical in helping social insurance coverage reach the last mile. Not only should they be involved in providing community preventive services, but they should also be capacity-built to disseminate and rally communities behind the available social insurance schemes. There were cases of CHPs, who are called '*doctors*' by their communities in the context of the study, saving lives by letting beneficiaries know they can access care through the program. In the Kenyan context, CHPs have been majorly involved in community Mother and Child Health and other PHC interventions but not in expanding community health insurance coverage. This project confirmed their effectiveness in this regard.

*'When I started getting sick, that doctor remembered that he had enrolled me in the NHIF, so he did not know if I was in it or not*

*because I was really sick. When he went to.....he found my name was there and I could be treated any place. So I started treatment with NHIF.'*

This is an example of CHP linking people to care, saving a life, and getting someone to the hospital who otherwise would have stayed home while sick and left to unknown consequences. This finding supports evidence from a previous study, which found that 16% of Kenyans avoid seeking medical care because of financial constraints (Toroitich, 2022).

### Challenges in Accessing Health Care

The most prominent challenge reported by participants in accessing care was the unavailability of medicine in health facilities. Since the inception of devolution in Kenya, County Governments have faced numerous challenges in ensuring an uninterrupted supply of health commodities in all public health facilities. Previous studies have shown that the average availability of essential medicines in public health facilities is about 44%, in comparison to 72.4% in private health facilities (Toroitich et al., 2022).

*'It is very inferior. You know medicines are hospitals.'*

*M: Hospitals are medicine*

*R 1: Hospitals are medicine. Sometimes you can come with a child, and probably there is no money, so I have the card. Going to buy medicine, will you go with the card to the chemist? Won't you have to go with money, the cash that you have? That is what makes it when you come with the card here; it is not functioning, and you are sent outside for everything. This is what makes me have to go elsewhere.'*

*'You could have a patient who has been severely overwhelmed by sickness; when they are brought here, they just stare at you; you could even have the card, but when you get there, it is not functioning. You end up wishing that you went elsewhere.'*

*Human resource challenges are another major obstacle towards the achievement of UHC, as was reported by the beneficiaries. The excerpts below provide more insight.*

*'The doctor on duty is only one when he goes for lunch; there is no doctor who can handle clients? You can wait there till you become tired; even a patient can die when you are waiting for him.'*

*'So the delay is something I see, and even the medicines are also a challenge. Medicines to be gotten is a problem.'*

*'If there is medicine in the hospitals, that is good. Even though someone does not have the card, they will be treated. They will not die in the house; you go to the hospital.'*

### **Involvement in Socioeconomic Empowerment Activities**

Most participants were involved in socioeconomic empowerment activities, which were meant to enable them to pay for their health insurance at the end of the project. The projects were mainly vegetable farming and poultry farming. One thousand five hundred and fifty were supported with a variety of African leafy vegetables, 200 with sweet potato vines, and 200

with 14 chicks each. During the life of the pilot, the beneficiaries managed to pay two hundred and fifty shillings every month to a County centralised account that was to be used in topping up payments for subsequent years.

However, delays in rains and lack of irrigation capacity led some beneficiaries to keep their seeds for a long time, thus delaying the expected gains. As shown in the excerpts below, some farmers also reported that their chickens died soon after delivery. The cause of death was not clear, but there was no follow-up by the project to advise the farmers on how to treat their poultry. As shown in the transcripts below, most farmers expressed optimism about being able to pay for their insurance if their farming project succeeded.

*'.....Something like vegetable farming, I can get money from there to pay NHIF. It can also help me personally like now there are no vegetables. Then the chicken, it is just that diseases have killed the chicken.'*

*'...We have no means of being helped; the help is maybe business, help maybe breeding things, and you know when you are near water here, even when you breed things like chicken, it will cost you much because of treatments because of the humidity from there. Maybe some will not feel well, and you will see many animals, but even if it is a chicken, you need a good fence and house in which they will live as chickens when you have a good fence. But if someone just gives me chicken and they room around, you will be surprised monitor has caught it.'*

### **Facility Utilisation**

The dispensary served more participants than the hub, which is a level 4 facility in the project's catchment area. As shown in Figure 2 below, the dispensary served more clients than the rest of the facilities. This can be explained by the fact that the facility's catchment area is bigger and because it offers better services, as shown in the excerpts below. The hub and the health centre always lacked drugs. This finding affirms that the services offered at level two facilities cater for

most medical needs of the population. Having higher-level facilities does not necessarily mean improved service delivery.

**Figure 2: facility visits by the beneficiaries.**

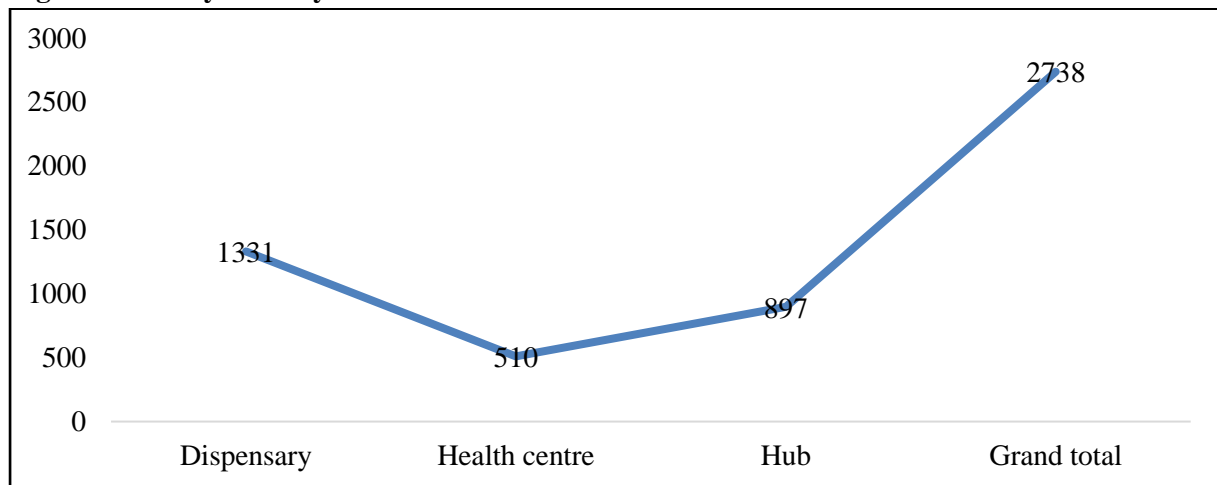
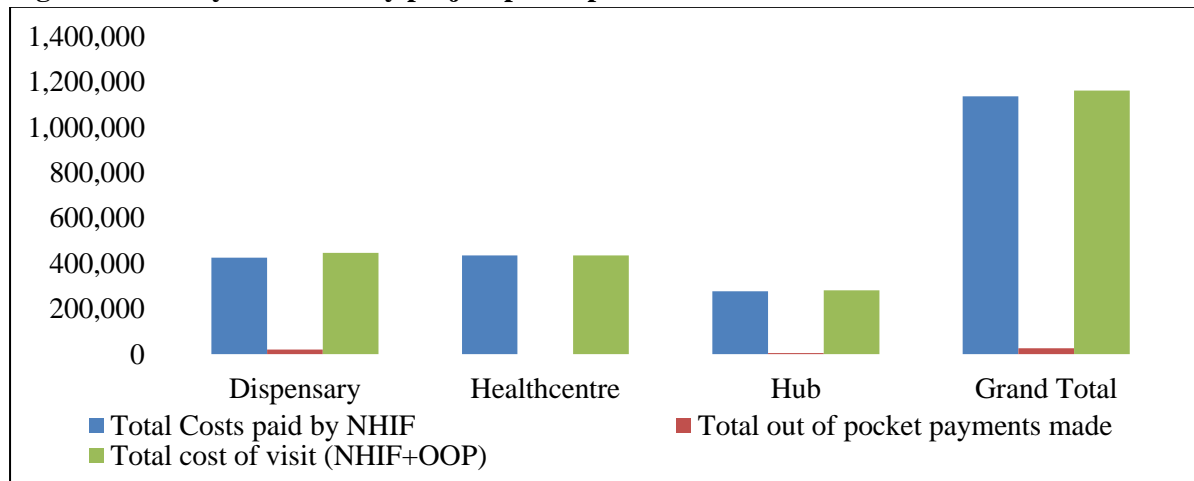


Figure 3 below shows facility utilisation by the project participants. Worth noting is that Out-of-pocket (OOP) payments were recorded but to a much-reduced proportion. This finding confirms that insurance subsidy programs are important in reducing OOP, especially as Busia ranks among

the Counties with high OOP. Additionally, the subsidy program provided revenue to the health facilities through NHIF in payment for services rendered, thus enabling them to finance their operations sustainably.

**Figure 3: Facility utilization by project participants**



**DISCUSSION**

Subsidised insurance enabled most households to access care, as shown by our results. The subsidy was effective in improving health-seeking behaviour. The initial study done at the commencement of the project found that Health insurance was not affordable for a majority of households. The number of beneficiaries who accessed care confirms the importance of

subsidising health insurance coverage for vulnerable households in communities. Additionally, Community Health Promoters (CHPs) were very instrumental in informing community members of the availability of the cover. There were instances where beneficiaries were ill and stayed home but only went to the hospital upon the intervention of the CHP. This is evidence of the importance of CHPs as being the

link between communities and the health system (LeBan et al., 2021).

CHPs in Kenya have not been actively involved in the health insurance sphere. Most programmes train CHPs in service delivery and growth monitoring at the household level. These findings point towards CHP effectiveness in enhancing community enrolment in social health insurance because of their everyday interaction with their communities.

The major challenges reported by beneficiaries while seeking care at the facilities were delays in service delivery and inadequate drugs. This finding further confirms that the implementation of UHC and successful retention of clients into Social Health Insurance heavily rely on the functionality of health facilities (Anasel & Kalolo, 2023). Subsidising health insurance and enrolling communities for this project created demand, but the facilities had staff and commodity supply inadequacies that limited the success of the UHC pilot.

The UHC project was mainly targeted towards vulnerable households who did not have income to enable them to pay for health insurance. The families who participated in the agricultural socioeconomic empowerment initiatives reported being able to raise money to pay for health insurance. This finding insinuates that while journeying towards UHC, Kenya should invest in socioeconomic empowerment, especially for the hard-core poverty population. The hard-core poverty headcount rate for individuals at the national level is 5.8 per cent in 2021, implying that 2.8 million people live in conditions of abject poverty and are unable to afford the minimum required food consumption basket. The proportion of the hard-core poverty population is even higher in rural areas at 7.8% (The Kenya Poverty Report, Kenya National Bureau of Statistics, 2021).

## CONCLUSION AND RECOMMENDATIONS

Having communities enrol for health insurance is a good step towards achieving UHC. However, the functionality of the facilities in terms of staff,

turnaround time and commodity availability are the most important drivers towards delivering health care to the last mile. The County and National Governments should, therefore, invest more in Primary Health Care facilities since they are closest to the masses and are important as the first point of contact with the health system. The operational status of health facilities can encourage or discourage patients from seeking care in higher-level government health facilities.

Having sufficient doctors in the hospital, eliminating delays in accessing care by patients while at the facility and reducing stockouts would improve patient experience and restore confidence in the public health system. Finally, the other important learning from this project was that the socioeconomic empowerment projects designed for communities should fit into the context. Factors such as climatic conditions, availability of resources to sustain the ventures before profits are realised, and community involvement in choosing a suitable project would yield more success in elevating communities from poverty and enhancing insurance coverage.

## REFERENCES

- Anasel, M. G., & Kalolo, A. (2023). Health Commodities and Technologies. In *Leadership and Governance in Primary Healthcare* (pp. 65-77). CRC Press.
- Ifeagwu, S. C., Yang, J. C., Parkes-Ratanshi, R., & Brayne, C. (2021). Health financing for universal health coverage in Sub-Saharan Africa: a systematic review. *Global health research and policy*, 6, 1-9.
- Kenya County Fact sheets, 2022. Commission on Revenue Allocation. <https://cra.go.ke/wp-content/uploads/2022/06/Kenya-County-fact-sheets-Report-Final-Res.pdf>
- LeBan, K., Kok, M., & Perry, H. B. (2021). Community health workers at the dawn of a new era: 9. CHWs' relationships with the health system and communities. *Health Research Policy and Systems*, 19(3), 1-19.

Maritim, B., Koon, A. D., Kimaina, A., Lagat, C., Riungu, E., Laktabai, J., ... & Goudge, J. (2023). "It is like an umbrella covering you, yet it does not protect you from the rain": a mixed methods study of insurance affordability, coverage, and financial protection in rural western Kenya. *International journal for equity in health*, 22(1), 1-13.

Mercer, T., Gardner, A., Andama, B., Chesoli, C., Christoffersen-Deb, A., Dick, J., ... & Laktabai, J. (2018). Leveraging the power of partnerships: spreading the vision for a population health care delivery model in western Kenya. *Globalisation and health*, 14(1), 1-11.

The Kenya Poverty Report, Kenya National Bureau of Statistics. (2021). Based on the 2021 Kenya Continuous Household Survey. file:///C:/Users/salom/Downloads/Poverty%20in%20Kenya%20-%202021%20Report%2007062023.pdf

Toroitich, A. M., Dunford, L., Armitage, R., & Tanna, S. (2022). Patients Access to Medicines—A Critical Review of the Healthcare System in Kenya. *Risk Management and Healthcare Policy*, 361-374.