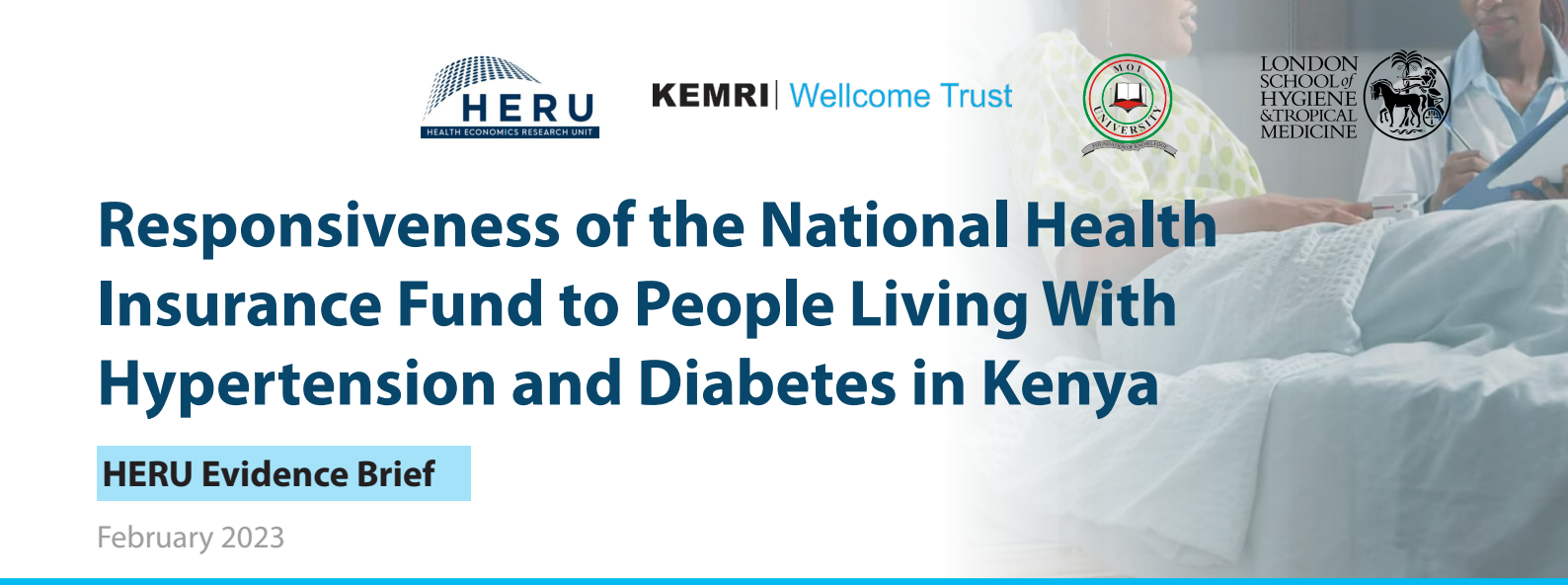

Responsiveness of the National Health Insurance Fund to People Living With Hypertension and Diabetes in Kenya

HERU Evidence Brief

February 2023

Introduction

Non-communicable diseases (NCDs) are increasingly contributing a substantial share of the burden of disease in Kenya. In addition to health impacts, NCDs can pose a high economic burden to households, impairing access and leading to catastrophic health expenditures - financial difficulties that households face when they spend high amounts of their income on healthcare expenditures. The National Health Insurance Fund (NHIF) is a public health insurance mechanism with the mandate to provide social health insurance to the Kenyans. In 2015, the NHIF expanded its national health insurance schemes' benefit package to include outpatient services and specialised services that included NCDs (figure 1). This expanded benefit package was dubbed **"Supa Cover".**

KEMRI-Wellcome Trust, in collaboration with Moi University and the London School of Hygiene and Tropical Medicine conducted a mixed methods study to assess the responsiveness of the NHIF national scheme to people living with hypertension and/or diabetes. We considered the NHIF national scheme to be responsive if was effective in protecting households from catastrophic health expenditures and enhanced access to health services for people living with hypertension and/or diabetes.

Key Messages

- The NHIF benefit package expanded access to services for people living with hypertension and/or diabetes.
- The NHIF benefit package inadequately covered the range of services needed by people living with hypertension and diabetes.
- As a result, the NHIF national scheme provided a low depth of cover (30%), implying that household still had to pay for over 70% of their healthcare costs out of pocket.
- The NHIF did not protect households that have an individual living with hypertension and/or diabetes from catastrophic health expenditures.
- The NHIF benefit package did not prioritise preventive and promotive services for NCDs.
- The NHIF premiums for the National scheme were unaffordable. This contributed to the high observed NHIF attrition rate (76.3%).

Study Approach

We collected qualitative data using in-depth interviews (n = 39) with county level health stakeholders and health facility respondents and focus group discussions (n=4) with people living with hypertension and/or diabetes. We also collected quantitative data by following up two groups of households (no = 888) living with hypertension and/or diabetes over a period of 12 months, collecting data in four waves over this period. One of the follow-up groups had active enrolment with the NHIF at the start of follow-up while the second group did not have active enrolment with the NHIF. This study was carried out in Busia and Trans Nzoia counties in Western Kenya, where Moi university, Moi Teaching and Referral Hospital through AMPATH (Academic Model Providing Access to Healthcare) have partnered for several years with county governments to strengthen health systems across various care levels. The study is part of a larger study that seeks to inform and support the scale-up of the Primary Health Integrated Care Project for NCD Conditions (PIC4C) model for the integrated management of people with hypertension, diabetes, and breast and cervical cancers in Kenya.

Findings

- **The NHIF benefit package expanded access to services for people living with hypertension and/or diabetes.** The expansion of the NHIF benefit package to include outpatient care and specialist services facilitated access to a range of services that they would otherwise have had to pay for OOP.
- **The NHIF benefit package inadequately covered the range of services needed by people living with hypertension and diabetes.** The NHIF Supa Cover package did not adequately cover the range of diagnostic, monitoring services, and did not explicitly cover medicines that people living with hypertension and/or diabetes needed.
- **NHIF members faced additional out-of-pocket costs because of administration charges, input supply shortages, and payments for services not covered.** Further, the reimbursements NHIF paid providers for inpatient and outpatient services were deemed insufficient to cover the cost of offering services. As a result, the NHIF national scheme provided a low depth of cover (30%), implying that household still had to pay for over 70% of their healthcare costs out of pocket (figure 2).
- **The NHIF did not protect households that have an individual living with hypertension and/or diabetes from catastrophic health expenditures.** The proportion of households that incurred catastrophic health expenditures due to direct medical costs was high (18%) and increased to 23% when transport costs were considered.
- **The NHIF benefit package did not prioritise preventive and promotive services for NCDs.** Key preventive and promotive services such as screening for NCDs were not included in the benefit package. The benefit package prioritised secondary and admission care, and care was mostly sought from hospitals and private health facilities rather than primary care services at lower-level facilities (figure 3).
- **The NHIF premiums for the National scheme were unaffordable.** The KES 500 (USD 5) per month premium was deemed to be beyond reach to most households, especially in rural areas. This contributed to the high observed NHIF attrition rate (76.3%).

Figure 1: NHIF Supa cover benefit package

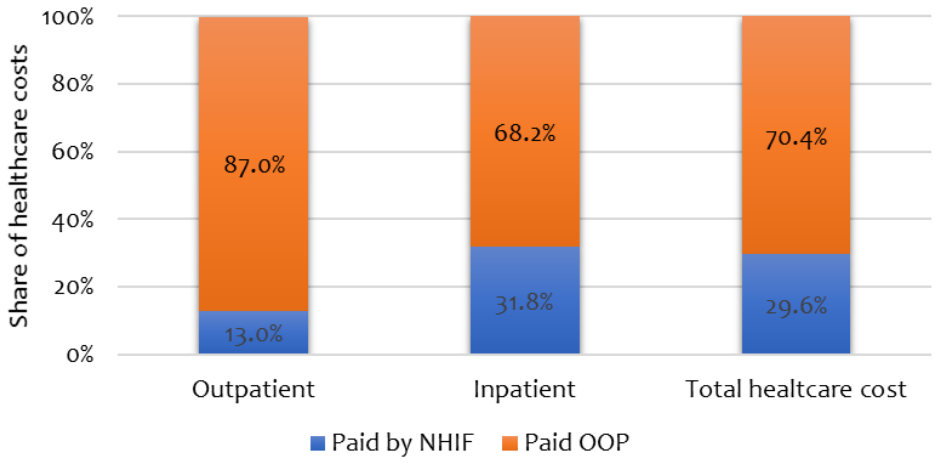

Figure 2: Proportion of healthcare costs covered by NHIF among NHIF active households

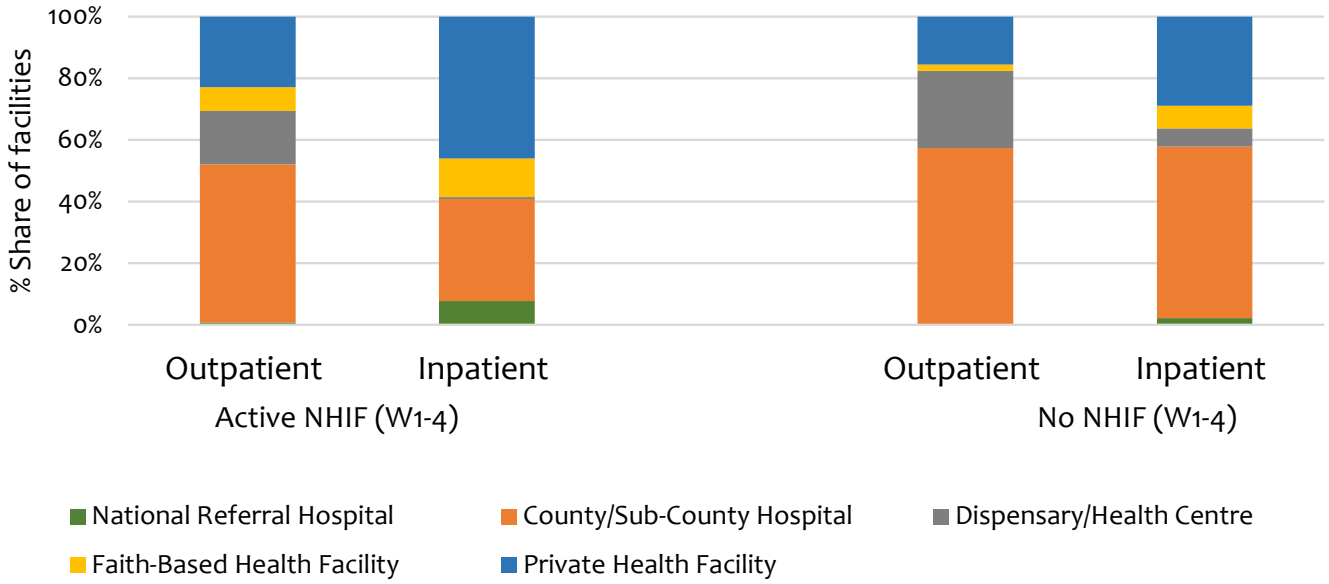

Figure 3: Healthcare facilities where people living with diabetes/hypertension sought care

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