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Health workers' Perspectives on the Usefulness of National Hospital Insurance Fund (NHIF) Adoption and Implementation in Kenya

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Abstract: **Adoption and Implementation of National Hospital Insurance Fund (NHIF) has always been popular in the recent years. Many hospitals and other health facilities have adopted the medical cover since users have increased because the government of Kenya made it compulsory that every employee in the country must get a deduction towards the cover. This paper is an attempt to investigate the usefulness of the NHIF scheme in Kenya from the perspectives of Health workers. The findings indicated that the hypothesis stating that there was no significant difference in perceived usefulness between gender groups of health workers holds since f – value in all cases was less than critical value at 5 percent level of significance (P > 0.05), hence leading to the acceptance of the stated hypothesis. The study concluded that a lot must be done to increase the understanding about the usefulness of NHIF to patients in Health facilities. More training and seminars needs to be arranged for health workers to provide vast experience on NHIF dealings.**

Keywords: **National Hospital Insurance Fund (NHIF), health facilities, Health workers.**

1. INTRODUCTION

In recent times, Health insurance worldwide has received great attention since governments are focusing of the health welfare of their citizens. The Bauhinia Foundation Research Centre Health Care Study Group**,** (2007) Hong Kong's health care is the envy of many people throughout the world. It leads many health care systems with some of the best vital statistics and performance measures. Hong Kong is facing many of the same problems other health care systems are facing. Health care reform proposals in the past are testimony to the concerns and need to develop a responsive and sustainable health care system for the people of Hong Kong. Rusa and Fritsche (2006), conducted a study in Rwanda assessing the Performance Based Financing (PBF) is an approach to health financing that shifts attention from inputs to outputs, and eventually outcomes, in health services. Whilst inputs are necessary to finance health services, a predominant focus on inputs has failed to deliver the results that are necessary, if the country is to achieve its Millennium Development Goals. The key premise in Output-based aid is that it "seeks to address weaknesses by delegating service delivery to a third party under contracts that link payment to the outputs or results delivered.

The National Health Insurance Scheme (NHIF) is the outcome of a1990-1992 study on the long-term options for financing health services in Tanzania. It was established by an Act of Parliament: Act No. 8 of 1999. The scheme commenced its operations on 1st July 2001 by members and their respective employers starting to contribute. Some of the principles in establishing the NHIF were: strengthening cost sharing in government health facilities by providing an opportunity for formal sector employees to contribute, providing health insurance to employees in the formal sector especially after the introduction of user-fees, allowing free choice of providers to civil servants who were previously restricted to government health facilities, enhancing health equity among employees in the health sector, providing an environment for the growth and participation of the private sector (Health care financing in Tanzania, 2005).

According to Kiwala et. all (2006) stated that, NHIF was introduced in line with other complementary sources of financing mechanism with the broad objective to generate additional resources to complement the government budgetary allocations which have been insufficient to meet all the requirements of the health sector. It observed that timeliness of payment from NHIF was a problem, thus there are delays in payments caused by the late claiming, which caused by

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technical problems and unqualified staff. Over the last decade, it has become clear that Kenya's National Hospital Insurance Fund (NHIF) is the vehicle through which the government hopes to eventually offer health insurance to all Kenyans (Magero and Lakin 2012). Since 2006, the fund has increased its membership of formal and informal sectors alike, and the share of national health resources that are under its direct management. The recent controversial attempt to expand outpatient coverage is also intended to position NHIF for a larger role in the health system.

However, if NHIF is going to anchor universal health coverage in Kenya, then it must be capable of managing its finances in an effective manner. Moreover, the Fund, like all state corporations, collects and spends public money and must report on its use of funds to permit effective oversight by Parliament and the public. State corporations in Kenya manage massive sums: approximately 610 billion KSh (US$7 billion) in FY 2011/2012, of which 139 billion KSh constituted government funds from the budget. Put into perspective, that is roughly 13 percent of budgeted expenditure for FY 2011/2012. Given their public role, state corporations like NHIF must be held accountable for the money they use, and this requires timely and transparent financial reporting. The objective of this paper was to investigate the perceived usefulness of NHIF to health workers in Kenya. This study will benefit many health facilities in planning well and managing their facilities. It will also benefit health workers in understanding how useful it is in implementing the cover in Kenya.

2. REVIEW OF RELATED STUDIES

Komos (2007), conducted a study on new technology which extend the life of a failing organ for patients suffering from heart or lung disease while they wait for a donor organ by using ventricular assist devices (VAD), He found that Ventricular assist devices stabilize adults with heart disease, and act as a mechanical "bridge" for patients waiting for a donor heart and it concluded that the electronic health card pilot will take place in a small municipality through the Bulgarian National Health Insurance Fund (NHIF).

Cecere (2009), conducted study about annual deaths which associated with lack of health insurance and he found that 40 percent increased risk of death among the uninsured, then he concluded that the widening gap in the risk of death between those who have insurance and those who do not is the improved quality of care for those who can get it.

Mohammad (2009), examined inadequate integration in health especially between public and private sectors and found that the greater inequity and public outcry also equity in access to private sector physically concentrated to urban areas and financially was mainly for those who can afford especially inpatient care. He concluded that implementation of the National Health Fund Management should be incremental, path dependent and most appropriate for the country.

Peters, (2009), identified various strategies used to improve health services in low income countries, also determined the factors that helped and hindered implementation of strategies, using a systematic search of electronic database of 150 studies sample and found that some of the single strategies were found to be effective and removal of financial barriers to access care, increase in the number of health workers, changes in physician behavior and change to drug procurement system.

Bhattacharyya, (2010), examined using content analysis and constant comparison to characterize strategies, focusing on business processes, using an initial sample of 46 studies, 10 case studies of exemplars were developed spanning different geography, disease areas and health service delivery models and found that ten organizations had innovations in their marketing, financing, and operating strategies and information on the social impact of these organizations was variable, with more data on availability and affordability and less on quality of care, then concluded that private sector organizations demonstrate a range of innovations in health service delivery that have the potential to better serve the poor's health needs and be replicated.

Mwafongo (2010), created awareness of the key role that circumcision could play in reducing HIV infections, and was expected to start assisting men who wanted to undergo the procedure. And research established that circumcision could reduce the risk of HIV infection by up to 60 per cent. The findings supported by data from regions in which circumcision was common, where it observed that HIV infection among men was relatively low compared to regions where circumcision is not practiced. Then concluded that although circumcision was a form of plastic surgery, a category of health service not covered by the Fund, NHIF would pay for the procedure due to its importance.

Singhal (2011), survey of private sector employers offers a snapshot of attitudes that suggests the shift away from employer-provided health insurance could be greater than expected with sample size of 1,300 employers across industries, geographies, and employer sizes, as well as other proprietary research, found that reform will provoke a much greater

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response. Then concluded that US health care reform sets in motion the largest change in employer-provided health benefits in the post–World War II era. While the pace and timing are difficult to predict.

Deloitte Consulting Limited, (2011), conducted a strategic review of the operations of the NHIF with a view to improving the efficiency and reach with a view of the NHIF. They found that the health insurance market structure in Kenya comprises private health care insurance fund scheme as well as national hospital insurance fund. The private pre-paid scheme range from traditional indemnity insurer, community based health schemes, employer schemes and health maintenance organizations. As a result, the market has many fragmented risk pools and most financing is out of pocket. The market structure is also affected by supply side constraints which include poor regulation of providers and high provision costs. The review concluded that the form of contribution need to be determined, the NHIF act need to be amended to include an automatic mechanism of increasing contributions, taking into account inflation, regular actuarial reviews, subject to maximum cap and the Government through ministry of medical services and the ministry of finance should consider other sources of fund to supplement worker's contribution.

Rand health (2012) conducted a study on advances understanding of health and health behaviors and examined how the organization and financing of care affect costs and quality, and founded that health insurance, health care reform, health information technology, and women's health have to be considered then concluded with four strategies to restrain health care spending growth and maintain quality: foster efficient and accountable providers, engage and empower consumers, promote population health, and facilitate high-value innovation.

3. RESEARCH METHODOLOGY

The involved OPD, IPD, Pharmacy, treasury and management which provided a clear picture of NHIF system in Nyamache level 4 hospital. The study adopted stratified sampling technique since there was a number of stratas as mentioned above. By the use of questionnaires 94 usable research tools were returned which used for analysis. The researcher utilized Descriptive statistics and ANOVA was used to test the hypotheses to find the significant association between the independent and depended variables.

4. FINDINGS

4.1 Profile of Respondents

Under profile of respondents the researcher look about gender –wise and age – wise. Gender-wise have four tables while age – wise has three tables therefore demographic profile contains seven tables. In gender-wise perspective out of 94 respondents 39 were male while 55 were female which represents 41.5% and 58.5% respectively. In age-wise perspective out of 94 respondents 16 were under 29, 32 were 30-39, 31 were 40-49, and 15 were above 50. This represents 17%, 34%, 33% and 16% respectively.

4.1.1 Gender – wise distribution of respondents

Table 1 indicates that most of NHIF workers in the hospital are aged between 30 to 49 years which represents 67% out of this 26.6% are male and 40.4% are female.

Table 1: Age Distribution of respondents (Gender – wise)

Age	Gender		Total
	Male	**Female**	
Under 29	5 -5.3	11 -11.7	16 -17
30-39	12 -12.8	20 -21.3	32 -34
40-49	13 -13.8	18 -19.1	31 -33
Above 50	9 -9.6	6 -6.4	15 -16
Total	39 -41.5	55 -58.5	94 -100

Parenthesis indicate %, χ^2=3.021,df 3, P>0.05

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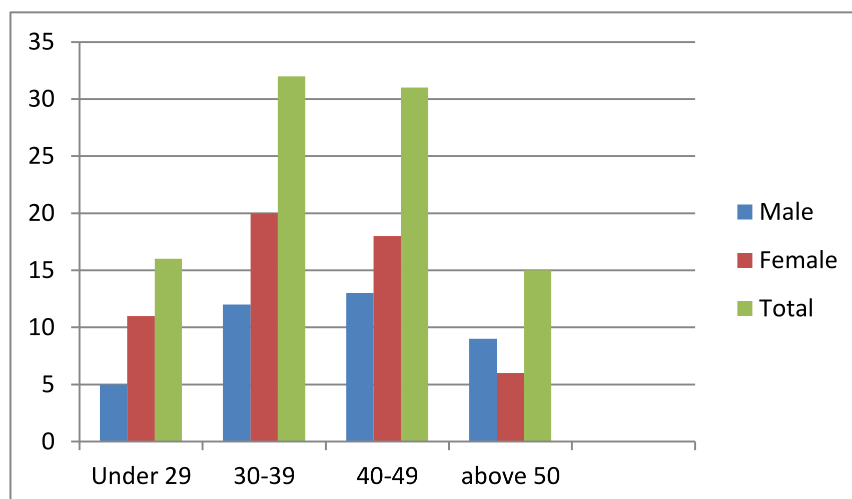
Out of 32 health workers 20 (21.3%) from distribution are female and 12 (12.8) are male, the same apply of 31 heath workers aged between 40 to 49 out of which 18 (19.1%) from distribution are female while 13 (13.8%) are male. But things comes different to health workers who are above 50 years, out of 15 workers 9 (9.6%) are male while6 (6.4%) are female. The reason is that most of marriage nurses (female) cannot stay longer in one organization because they are transferred to their spouses. In general female are seems to be higher than male due to the nature of work thus most of nurses are female.



The Chi² result indicates that calculated Chi² value (χ^2=3.021) is less when comparing with the table value ($P>0.05$) leading to the accepting of null hypothesis which indicated that there is no significant difference between age of health workers and the gender representation.

Table 2: Experience as health worker distribution of respondents (Gender-wise)

Years	Gender		Total
	Male	Female	
Less than1	3 -3.2	4 -4.3	7 -7.4
01-Mar	5 -5.3	8 -8.5	13 -13.8
03-May	7 -7.4	8 -8.5	15 -16
More than 5	24 -25.5	35 -37.2	59 -62.8
Total	39 -41.5	55 -58.5	94 -100

Parenthesis indicate %, χ^2=0.236,df 3, $P>0.05$

Table 2 indicates that more than half of respondents have experience in health services since the data shows that 59 out of 94 have experience of more than 5 years which represents 62.8%. And also out of 59 you may find that 35 (37.2) from distribution are female and 24 (25.5%) are male still female are leading in experience as health workers. Even those with less than 1 year experience out of 7 workers 4 (4.3%) are female and 3 (3.2%) are male. So female are recruited for health work than male. Having enough experience may lead the good performance if they get exposures for seminars and in-service training together with good work conditions.

The Chi² results indicates that the calculated Chi² (χ^2=0.236) is less than critical value at 5 percent level (P=0.05) therefore the null hypothesis is accepted which indicates that there is no significant difference between gender and years of experience as health workers.

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4.2 Frequency Analysis on Perceived Usefulness of NHIF

The perceived usefulness of NHIF has eight statements of questionnaires some of them are positive and some are negative so as to avoid bias to the respondents. The result on table 3indicates that, S6 is the highest score where by majority of respondents suggested that service should be improved which scores 400, thus out of 94 respondents 35 (37.2%) were strongly agree and 42 (44.7%) were agreed. The reason for improvement is that the facility under study has no separate department special for NHIF patients so members are waiting for a long time to receive service.

S5 is the second highest score, that the scheme established good system of providing services. The score is 345 out of 94 respondents, 33 (35.1%) were agreed and 24 (25.5%) were strongly agreed due to the reason that NHIF members have separate window for medication and reception. Also their data differs from other patients because they have separate records especially on file keeping.

S4 is the third score of 338 where by out of 94 respondents, 48 (51.1%) were agree and 16 (17%) were strongly agreed, the reason is that now days every member know his/her rights of receiving services and every departments have written documents concerning the services delivered.

S7 is the lowest score of 223 where by majority of respondents suggested that the system should not be abolished contrary to the statement. Out of 94 respondents 29 (30.9%) were disagree and 24 (25.5%) were strongly agree. The system is good but some of issues like drugs, supplies and equipments, separation of departments and qualified staff should be improved.

S8 is last but one and score 228, the majority of respondents disagreed with the statement, out of 94 respondents, 37 (39.4%) were disagree and 21 (22.3%) were strongly disagree. Therefore the system is not difficult to adopt but need to be improved.

Table 3: Perceived Usefulness of NHIF

SNO	STATEMENT	SA	A	N	D	SD	TOTAL SCORES
S1	Retired members' cards are collected in the health facilities	17 (18.1)	41 (43.6)	18 (19.1)	10 (10.6)	8 (8.5)	331
S2	Retired members with their spouses are getting services by using new cards	21 (22.3)	37 (39.4)	17 (18.1)	14 (14.9)	5 (5.3)	337
S3	Dependants of retired, terminated and death members are no longer receive services	10 (10.6)	30 (31.9)	25 (26.6)	23 (24.5)	6 (6.4)	297
S4	NHIF members get knowledge about the scheme when joining the scheme through meetings, radios, magazines and television	16 (17.0)	48 (51.1)	11 (11.7)	14 (14.9)	5 (5.3)	338
S5	The scheme established good system of providing services	24 (25.5)	33 (35.1)	21 (22.3)	14 (14.9)	2 (2.1)	345
S6	The system of services have to be improved	35 (37.2)	42 (44.7)	14 (14.9)	2 (2.1)	1 (1.1)	400
S7	The system of services should be abolished	4 (4.3)	10 (10.6)	27 (28.7)	29 (30.9)	24 (25.5)	223
S8	The system is difficult to adopt	2 (2.1)	21 (22.3)	13 (13.8)	37 (39.4)	21 (22.3)	228

SA= Strong agree, A= Agree, N= Neutral, D= Disagree and SD= Strong disagree, Parenthesis indicate %,

4.3 Descriptive Statistics Analysis on the Perceived Usefulness of NHIF

The highest mean of 4.1489 is supported by scores of 400 in the descriptive analysis where by majority of respondents suggested that the system of services have to be improved. The second rank of mean average of 3.6702 supported by S5 with score of 345 where by majority of health workers agreed that the system established good system of providing services and rank 3 with mean of 3.5957 is supported by S4.

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Table 4: Perceived Usefulness of NHIF

SNO	STATEMENT	MEAN	SD	RANK
S1	Retired members' cards are collected in the health facilities	3.5213	1.16147	5
S2	Retired members with their spouses are getting services by using new cards	3.5851	1.14919	4
S3	Dependants of retired, terminated and death members are no longer receive services	3.1596	1.11010	6
S4	NHIF members get knowledge about the scheme when joining the scheme through meetings, radios, magazines and television	3.5957	1.10053	3
S5	The scheme established good system of providing services	3.6702	1.08150	2
S6	The system of services have to be improved	4.1489	0.82901	1
S7	The system of services should be abolished	2.3723	1.10701	8
S8	The system is difficult to adopt	2.4255	1.13108	7

Min=minimum, Max=maximum, SD=standard deviation.

The lowest mean of 2.3723 supported by the score of 223 in the descriptive analysis where by respondents responded that the system of services should not be abolished and also is not difficult to adopt as it ranked in number 7 with score of 228 in S8. They are ranked by numbers from 1to8 where by 1 has highest mean and 8 has lowest mean. Therefore the agreed statements have high means while disagree statements have low mean. Regarding measures of dispersion the high means have low standard deviation and vice versa. The researcher found that the system of providing services is acceptable by members according to their responses in S7 and S8 but need to be improved because members have enough knowledge for the services provided by NHIF.

4.4 Hypothesis Testing

Analysis of variance (ANOVA) was used to find out the association existing between gender groups and gender of respondents and the perceived usefulness. The researcher hypothesized various variables and gender characters. The researcher wanted to know whether there existed any significant difference between male and female health workers on their perceived usefulness opinion. One way Fisher's ANOVA was applied. The hypothesis stated that: *there is no significant difference in perceived usefulness between gender groups of health workers in Nyamache sub-county*. The result is provided on the table 5

Table 5: Difference in perceived usefulness between male and female workers

S/N	VARIABLES	F.VALUE	SIG	INTERPRETATI ON	DECISION ON H0
S1	Retired members' cards	1.306	0.256	Insignificant	Accept
S2	Retired members with their spouses	1.552	0.216	Insignificant	Accept
S3	Dependants of retire, terminated and death members	1.383	0.243	Insignificant	Accept
S4	NHIF members	0.646	0.424	Insignificant	Accept
S5	The system of providing services	0.366	0.546	Insignificant	Accept
S6	The system to be improved	0.41	0,839	Insignificant	Accept
S7	The system to be improved	0.008	0.928	Insignificant	Accept
S8	The system is difficult to adopt	0.006	0.941	Insignificant	Accept

df = 1,92; P = 3.84

The result indicates that the hypothesis holds since f – value in all cases is less than critical value at 5 percent level of significance ($P > 0.05$). Hence leading to the acceptance of the stated hypothesis. The table value was identified to be 3.84 and the degree of freedom was 1,92. This indicate that the sample was drawn from the same.

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5. CONCLUSION AND RECOMMENDATIONS

Basing on the findings, it was concluded that usefulness not perceived well due to the reasons that the patients must be satisfied with the services and not be discouraged because they are key elements in the scheme. The researcher still doubt about the skills, experiences and knowledge of health workers and their competency even lack of enough drugs and supplies. Being the discouragement of patients regarding the service delivered, the services have to be improved by employing the qualified personnel with medical ethics. Those may find a way of improving services, by advising the management on how to increase medical supplies and how to get enough space for attending patients.

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