POLICY Brief

Impact of social protection interventions for basic health care provision

Lessons learned from this study

This brief presents key findings of a two-year research study that compared implementation and impact of two social protection interventions for basic health care provision: the Community Health Plan (TCHP) in Nandi County, and the Kenyan National Free Maternity Services (FMS) and Free Primary Care (FPC) programs. The study focused on analyzing impact in terms of reaching the poor and specific sub-groups, the quality of care, the health service utilization, and out-of-pocket expenditures. The study also focused on the associations between social protection interventions and inclusive economic growth.

Brief description of interventions

The TCHP offered basic health insurance packages covering outpatient or inpatient and outpatient costs. It also involved a facility upgrading program. The FMS coverage comprises free maternity care, both inpatient and outpatient. The FPC program offers basic primary outpatient care.

Approach

The study used existing data from the Kenyan Demographic and Health Surveys (KDHS 2003, 2008-09 and 2014), the Health Monitoring and Information System (financial years 2011/12, 2012/13 and 2013/14), Kenya Household Health Expenditure and Utilization Surveys (KHHUES 2003, 2007 and 2013), two household surveys conducted in Nandi County in 2011 and 2014, and PharmAccess TCHP insurance claim data. Additional data on revenue and workload was collected in a representative sample of facilities in Nandi County in 2017. Stakeholders' inputs were also gathered during consultative meetings organized in 2015 and 2016.

Result highlights

• The Community Health Plan (TCHP) in Nandi County

The healthcare expenditures of those insured by TCHP were higher at baseline, which might suggest adverse selection into the program. The average healthcare expenditures of TCHP-insured decreased significantly from baseline to endline, which indicates improved financial protection among the insured. TCHP-insured visited private (both TCHP and non-TCHP) and TCHP mission

Implications and recommendations

Ministry of Health, County Governments and National Health Insurance Fund,

1. Improve the current monitoring framework in order to enhance effective devolution of health-related funds;
2. Sustain the gains of the FMS/FPC by addressing supply side related challenges that include essential medical supplies and human resources;
3. Expand the range of services covered by the fee waiver mechanisms, in particular for the poor and vulnerable that are most affected by cost barriers, to reduce the direct payment made at the point of consuming health care;
4. Target health improvements more equally across socioeconomic groups, not only improving the population average of healthcare utilization, health insurance coverage and health outcomes;
5. Step up strategies aiming to increase health knowledge to increase utilization of skilled delivery;
6. Carefully check potential interference effects on ongoing programs when introducing new interventions.

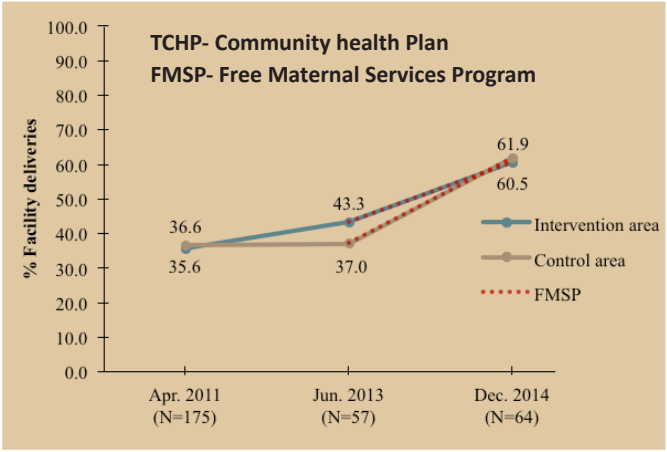
Policy makers and researchers

1. Allocate adequate time for studies that measure impact of programs in order to demonstrate change;
2. Incorporate relevant factors in impact studies, such as travel costs / distance to facilities.

facilities significantly more, while the uninsured visited the public non-TCHP facilities significantly more.

After the introduction of the FPC and FMS, the TCHP program was redesigned in May and June 2013. All enrolments were terminated and households had to actively re-enroll. However, enrolment did not catch up to the level before redesign due to the combined effects of low re-enrollment rate and high drop-out rates throughout the whole program period. This can to a large extent be explained by the availability of free basic care after mid-2013 in the FPC and FMS programs. Figure 1 shows that facility deliveries in Nandi County have increased substantively between 2011 and 2014, especially after introduction of the FMS program. This increase started earlier in the TCHP intervention area, possibly related to TCHP's facility upgrading plan.

Figure 1. Facility deliveries in Nandi County 2011-2014. Source: Nandi Household Survey 2011, 2014.



- *The Kenyan National Free Maternity Services (FMS) and Free Primary Care (FPC) programs*

Findings indicate substantial increases in absolute use of antenatal care and skilled delivery care following the implementation of both programs. The proportions of women who had 4+ antenatal care visits increased to 68% in urban areas and 51% in rural areas in 2014. For reference: the average in sub-Saharan Africa was 48% in 2015. The proportions of women who had skilled deliveries, which increased to 83% in urban areas and 51% in rural areas in 2014, were also high compared to the sub-Saharan regional average of 51%. Our analysis prompts to some caution in interpretation as the trend toward increased facility deliveries was already noticeable prior to the programs. Moreover, there was no comparison group to allow drawing robust conclusions.

Equity in access to services remains an issue to be addressed. The number of skilled deliveries between 2003 and 2014 increased in all groups, with a relatively better score among women in the poor quintile, but the absolute increase was higher in the richer quintiles of the women (Figure 2). Mother's education remains an important factor for skilled delivery among the poorest women in both urban and rural areas in Kenya. Children of higher educated mothers also have better nutritional status and are less prone to common child illnesses such as diarrhea and fever.

Figure 2. Utilization of skilled delivery by wealth quintiles in public and private facilities and equity indicators, 2003-2014. Demographic and Health Survey Data

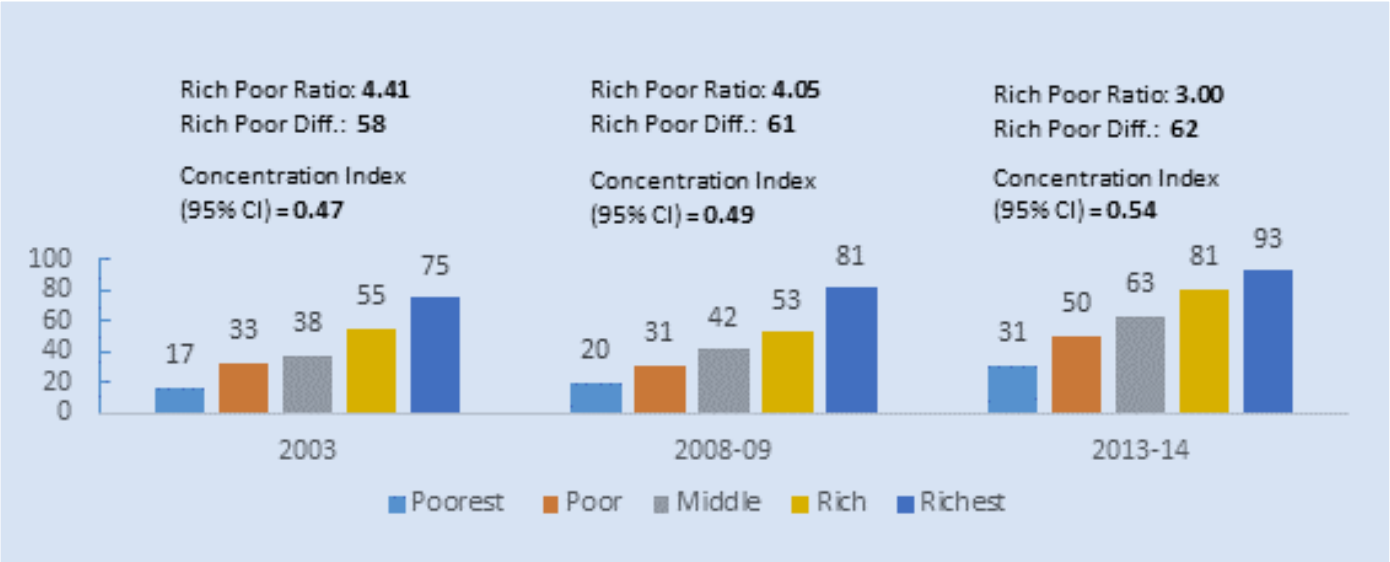
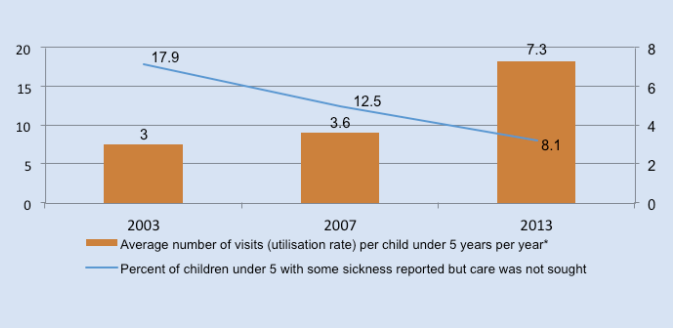


Figure 3: Average number of visits (utilization rate) and proportion of children under five years with reported illness but were not taken for treatment

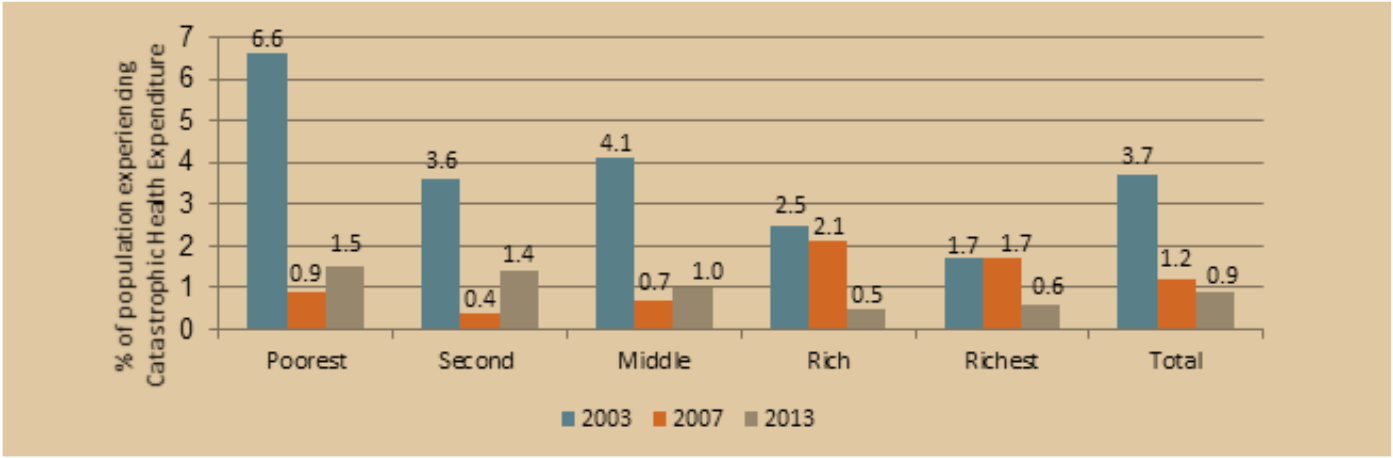


Utilization of outpatient health services by children under five years of age has improved with the total number of visits increasing threefold from 1.2m in 2003 to 3.6m in 2013. The average utilization rate also increase from 3.0 visits per child per year in 2003 to 7.3 visits per child per year in 2013 with public facilities the prefered provider (60 percent). Although a trend toward increased utilization of health services by children under five years of age is noted, it was already there prior to the FPC program (Figure 3). As expected, children under five years of age from the richest households make more outpatient and inpatient visits than those from poor households indicating inequality by wealth quintile in utilization of health services.

The incidence of catastrophic health spending has fallen over the ten year period from 4 percent in 2003 to about 1 percent in 2013. The richest quintile had the lowest incidence while the poorest had the highest incidence (figure 4). The number of households living below the poverty line also dropped signifcantly. Stakeholders interviewed unanimously attributed this positive trend to changes in the user fee policy over time.

An increase in utilization of health care services is expected to increase the workload of, and consequently puts more strain the health staff in clinics. However, no significant statistical evidence was found of negative effects of the free care programs on the quality of care. Further study into the effects are needed to investigate impacts of the free care programs on other aspects of clinical quality of care such as effectiveness, efficiency, safety and long-term impact.

Figure 4: Incidence of Catastrophic Out of Pocket payments (more than 40% of Non-food Expenditure)



Further findings and conclusion

Although there has been an absolute improvement in many health aspects in the last decade in Kenya, on average the wealthier, the residents of urban areas and the higher educated mothers benefitted more and experienced larger improvements compared to the poor, residents from rural areas and less educated women respectively. This demonstrates that health inequalities have increased in the study period (2008-2014). To meet the needs of these specific groups increased effectiveness of programs, such as free services or health insurance plans, can be realized through adopting a more targeted approach, such as mother education.

Findings also show that a smooth implementation of new policies asks for timely and sufficient information and funding flows in order for program managers to run their programs effectively. Inefficiencies in devolution are currently causing health facilities to be short of funding. This subsequently increases the risk of health facilities asking fees from patients for services that are nominally free.

The system of health financing is complex in Nandi and includes TCHP, FPC, FMS, National Health Insurance Fund and some smaller providers (AMPATH, Faulu, CIC, and Linda Jamii).There are significant overlaps in terms of packages and coverage among providers. The introduction of FPC and FMS interfered with TCHP and made impact evaluation effectively impossible.

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RESEARCH FOR INCLUSIVE DEVELOPMENT

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