Multi-country study on ability and willingness to pay for health insurance and save for health expenses in Kenya, Rwanda, Uganda and Tanzania

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Cross-Border Health Integrated Partnership Project (CB-HIPP). 2017. Multi-country study on ability and willingness to pay for health insurance and save for health expenses in Kenya, Rwanda, Uganda and Tanzania

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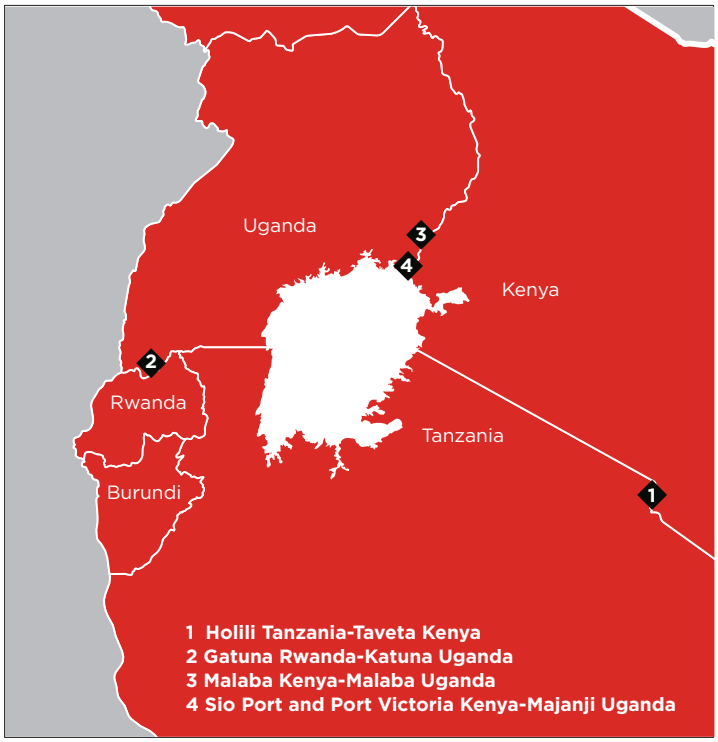
STUDY CONTEXT

The six partner states of the East African Community (EAC) are committed to enhancing economic, political and social integration. The partner states include Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda. Mobility across the EAC region has been facilitated by the EAC Common Market Protocol and the EAC's integration agenda. Movement of people increases the need for trans-national healthcare access. This will result in a greater need for healthcare financing products that expand healthcare access across borders, referred to here as portability. Recognizing this need, the EAC has developed a roadmap for extending portability of current social health protection (SHP) systems, including insurance. As a next step, the EAC is drafting a SHP portability bill that will provide a regulatory framework to support portability of SHP systems across the region.



The Cross-Border Health Integrated Partnership Project (CB-HIPP) is a regional project funded by the USAID Kenya and East Africa Mission and is implemented by a team of partners led by FHI 360. CB-HIPP is designed to extend quality integrated health services in strategic land and wet cross-border areas and other transport corridor sites in East, Central and Southern Africa. Through its partner Abt Associates, CB-HIPP conducted a study to generate evidence on the ability- and willingness to-pay for health insurance and ability and willingness to save for health expenses; to provide access to an integrated package of service, including HIV services, across the EAC region. This study seeks to provide evidence that will support EAC draft legislation for SHP portability and the implementation of portable SHP arrangements. In addition, CB-HIPP has used these data to model enrollment inputs for an actuarial analysis to price a portable integrated package of services.

STUDY DESIGN

CB-HIPP designed a multi-country study targeting cross border communities and specific mobile vulnerable populations (MVPs) - long distance truck drivers (LDTDs), fisherfolk, and clearing and forwarding agents (CFAs). CB-HIPP conducted a total of 888 household interviews and 963 MVP interviews between November 2016 and February 2017 from four cross border areas: Malaba Kenya-Malaba Uganda, Holili Tanzania-Taveta Kenya, Gatuna Rwanda-Katuna Uganda and Sio Port and Port Victoria Kenya-Majanji Uganda. CB-HIPP recruited household respondents at their households within five kilometers of the cross-border area while MVP respondents were recruited at cross-border points and landing beaches (fisherfolk). The study collected data through structured individual surveys. In addition, the study tested the willingness to pay (WTP) and willingness to save (WTS) for two product prototypes for health insurance and health savings which they were told could be used exclusively for health expenditures. The health insurance prototypes included the following services:

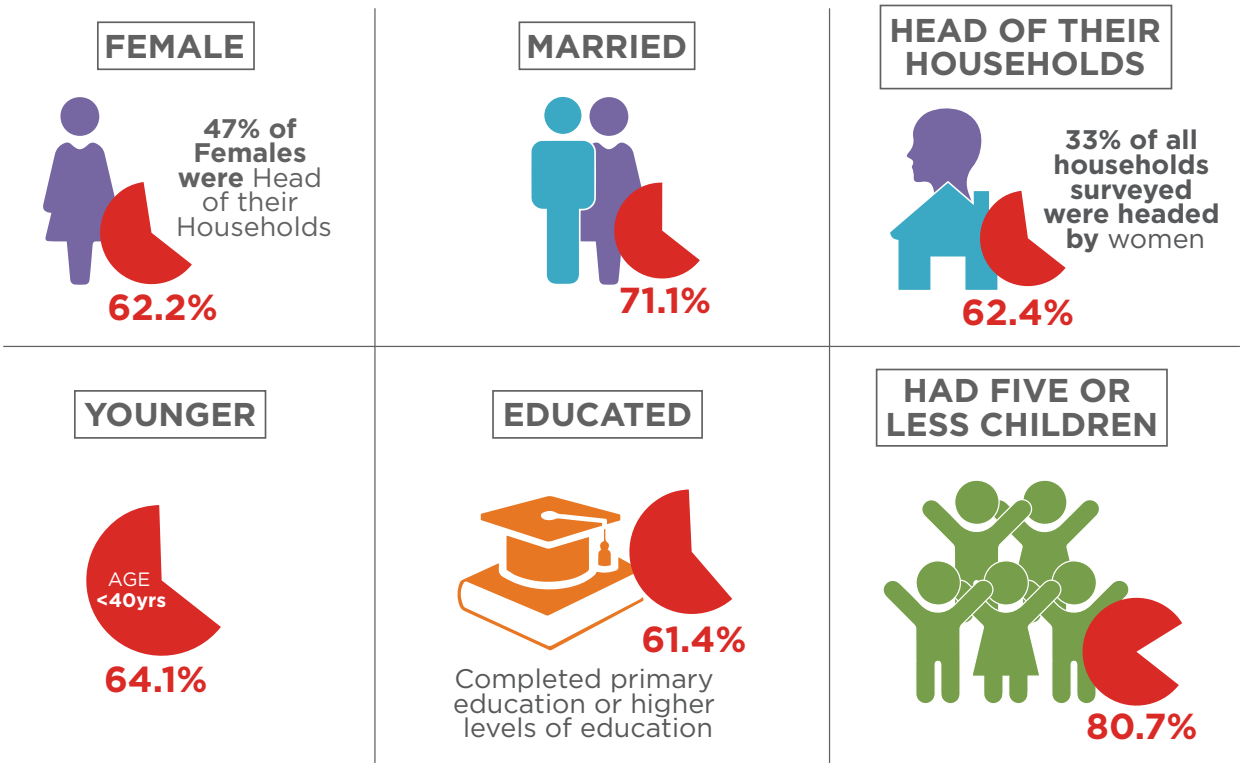
Data collected:

- Demographic and economic characteristics
- Health seeking behavior
- Healthcare financing behavior
- Use of financial services
- Willingness to pay and save for healthcare financing concepts

- Antenatal care
- Treatment of common illnesses like diarrhea, cough, malaria
- Treatment of sexually transmitted illnesses
- Family planning services such as condoms, pills, injectables, and intrauterine devices,
- Treatment of diabetes and hypertension
- Screening for cancer
- Treatment of Tuberculosis
- Treatment of HIV and AIDS ART treatment

The health insurance prototype provided coverage for households and also individual coverage for the MVP groups and therefore had different prices. Abt estimated ability-to-pay (ATP) through income and out-of-pocket (OOP) health spending as a proportion of monthly income, while ability-to-save (ATS) was estimated through savings specifically for health expenses and if savings were adequate for healthcare needs.

HOUSEHOLD SURVEY FINDINGS RELATED TO HEALTH SEEKING

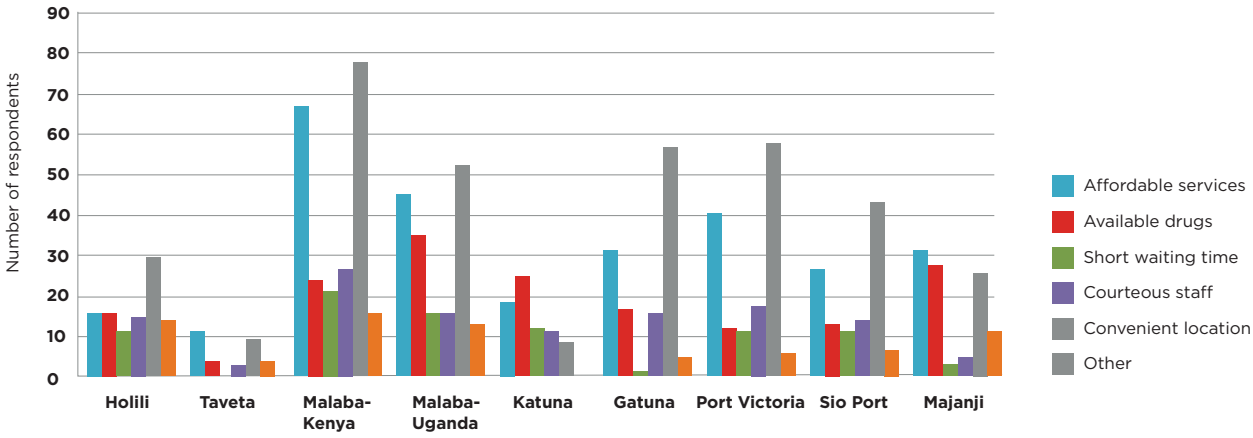


BEHAVIOR AND HEALTH EXPENSES

Majority of respondents were married and had five or less children

Affordability and convenience informed choice of their preferred health facility - Respondents most commonly cited service affordability and convenience of the facility location as the reasons for their choice of preferred facility as shown in Figure 1.

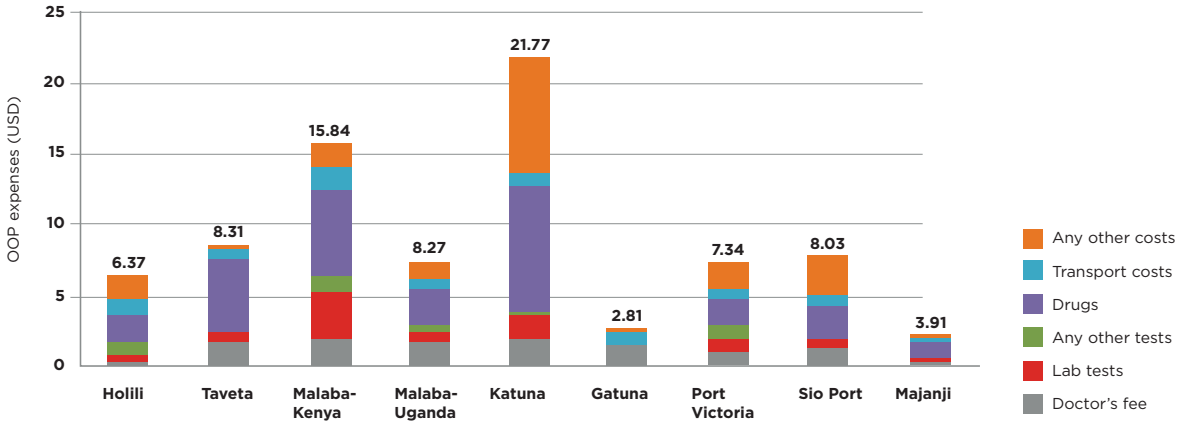
Figure 1. Reasons for choice of preferred health facility by cross border area



Households relied on out-of-pocket spending for health expenses - 73.4% of households rely on OOP spending to meet health expenditures and only 25.3% of households own health insurance. Overall, 36.5% of respondents reported delaying seeking healthcare because of lack of money to pay. The average OOP amount paid for the most recent outpatient visit varied from USD 2.81 to USD 21.77,

while OOP amounts for the most recent admission varied between USD 16.23 and USD 203.79. As shown in Figure 2, drugs were the highest component of OOP expenses at all cross-border areas. For an inpatient (IP) admission, doctors' fees were generally the highest component of OOP expenses paid by respondents.

Figure 2. Components of OOP expenses for outpatient services by cross-border area



Average monthly household income varied between USD 51 and USD 128 - Only 7.7% of respondents reported their income always met their household expenses. Comparing the cost of the most recent outpatient (OP) visit and IP admission expenses and average household income, one OP visit is 4.9% to 37.1% of mean monthly income while an IP admission is 24.3 to 203.5% of mean monthly income. Therefore, households are experiencing high OOP health spending, which can be catastrophic, and low monthly incomes may result in low ability to pay.

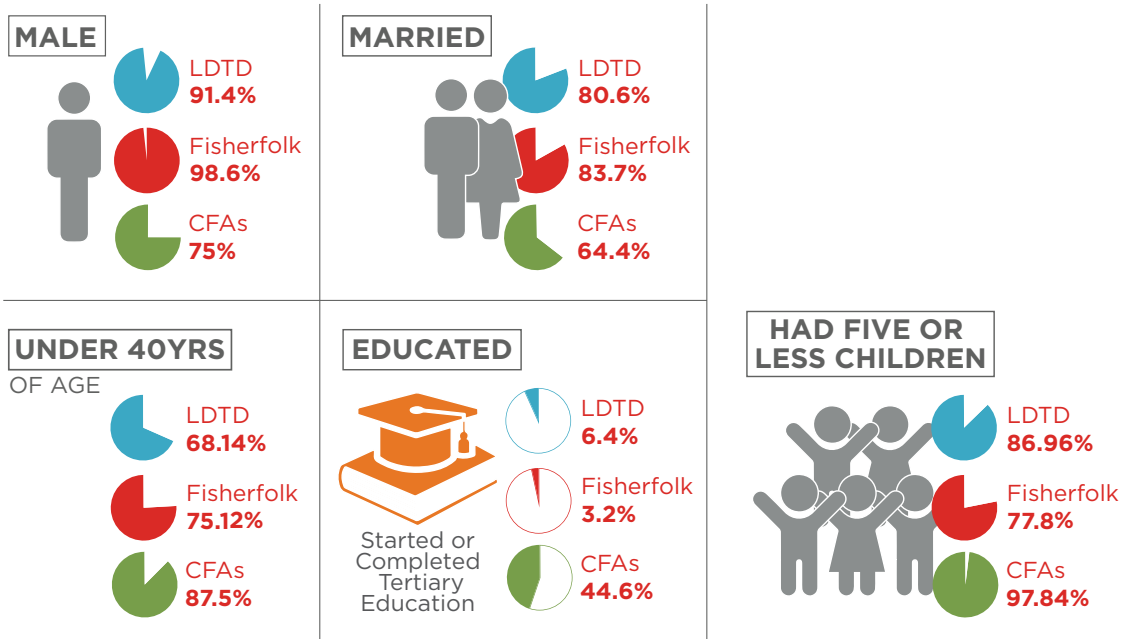
Half of respondents reported saving for health expenses - 52.9% of respondents reported saving for health care, but less than half of them (48.3%) reported the savings were adequate for their healthcare expenses. Females, younger respondents and respondents in Malaba Kenya-Malaba Uganda had higher ability to save.

Despite the health insurance prototype meeting their needs, few were willing to pay the price - In terms of WTP, 62.9% agreed the health insurance prototype met their needs, but only 28.1% were willing to pay its price of USD 6.7. The average maximum WTP varied across cross-border areas, between USD 0.6 and USD 3.0 per month, which was less than half of the USD 6.7 per month price. Factors associated with higher odds of being willing to pay more for the health insurance prototype include higher income and education, prioritization of health care, and use of formal healthcare services.

Respondents were more willing to save than pay for health insurance - Respondents were willing to save higher amounts than they were willing to pay for the health insurance prototype. Factors associated with odds of saving more for healthcare expenses include use of formal healthcare services, health insurance ownership, use of health insurance, and higher education attainment.

MVP SURVEY FINDINGS RELATED TO HEALTH SEEKING BEHAVIOR AND HEALTH EXPENSES

Majority of respondents were male and married

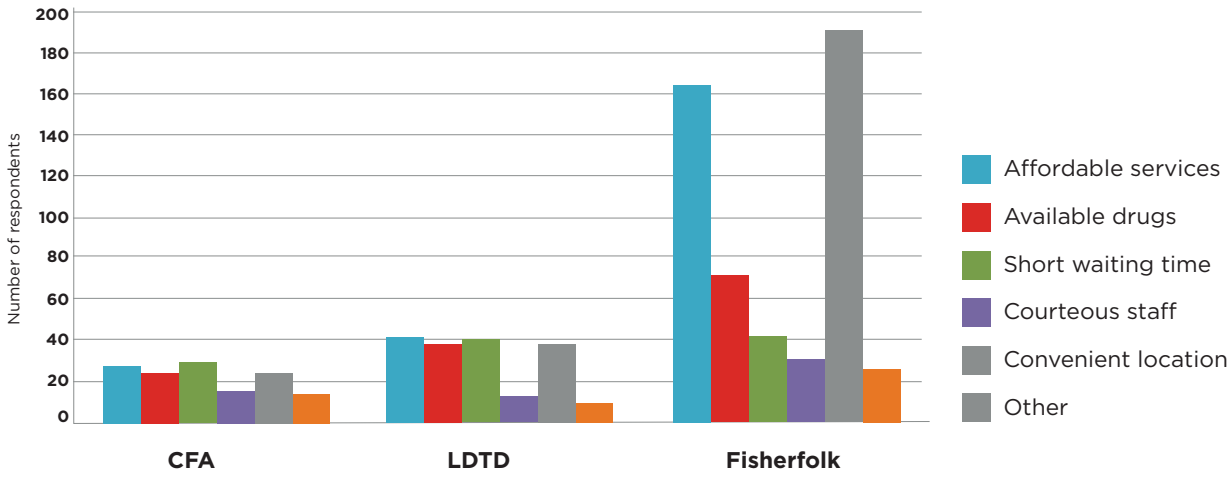


Fisherfolk had the highest reported use of healthcare services – Fisherfolk were also most likely to report a chronic illness, reported higher use of free health services, and were also the most likely to report forgoing healthcare due to lack of money. Fisherfolk also had the lowest health insurance ownership. Fisherfolk and LDTDs were more likely to have sought a healthcare service during work related travel. In terms of mobility, CFAs had fewer work-related trips over the past 12 months which were short in duration (median 0.5-1.5 weeks). LDTDs had ten times more work-related trips than CFAs with a median duration of one to two weeks. Fisherfolk had ten times the number of trips of LDTDs but time spent away from home varied across the different cross-border areas with a median of one week per trip.

One in four MVP incur health expenses while on work travel - 29.7% of MVP respondents reported incurring a health-related expense while on work related travel, while 13.8% of MVP respondents incurred health expenses outside their home country. The most common means of payment was through OOP payment.

Location and cost informed the choice of preferred health facility - Across all three groups, the top reasons for their choice of facility were convenient location, affordability of services, available drugs, and short waiting time (Figure 3).

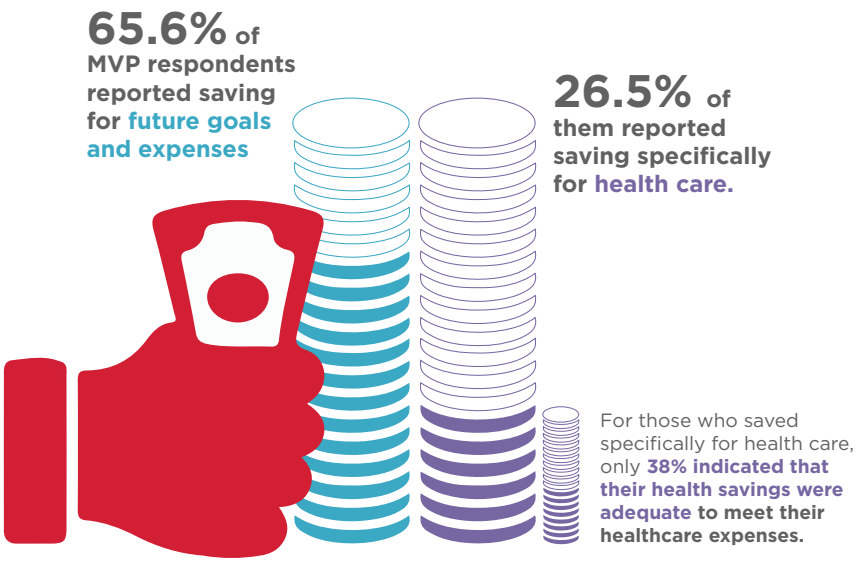
Figure 3. Reasons for choice of preferred health facility by MVP group



Health insurance ownership was lowest among fisherfolk - 23.2% of all MVP respondents owned health insurance; lowest among fisherfolk (4.8%) and higher among CFAs (29.8%) and LDTDs (42.4%). Only 17% of insured respondents reported their health insurance could be used outside their home country, and these respondents owned private health insurance.

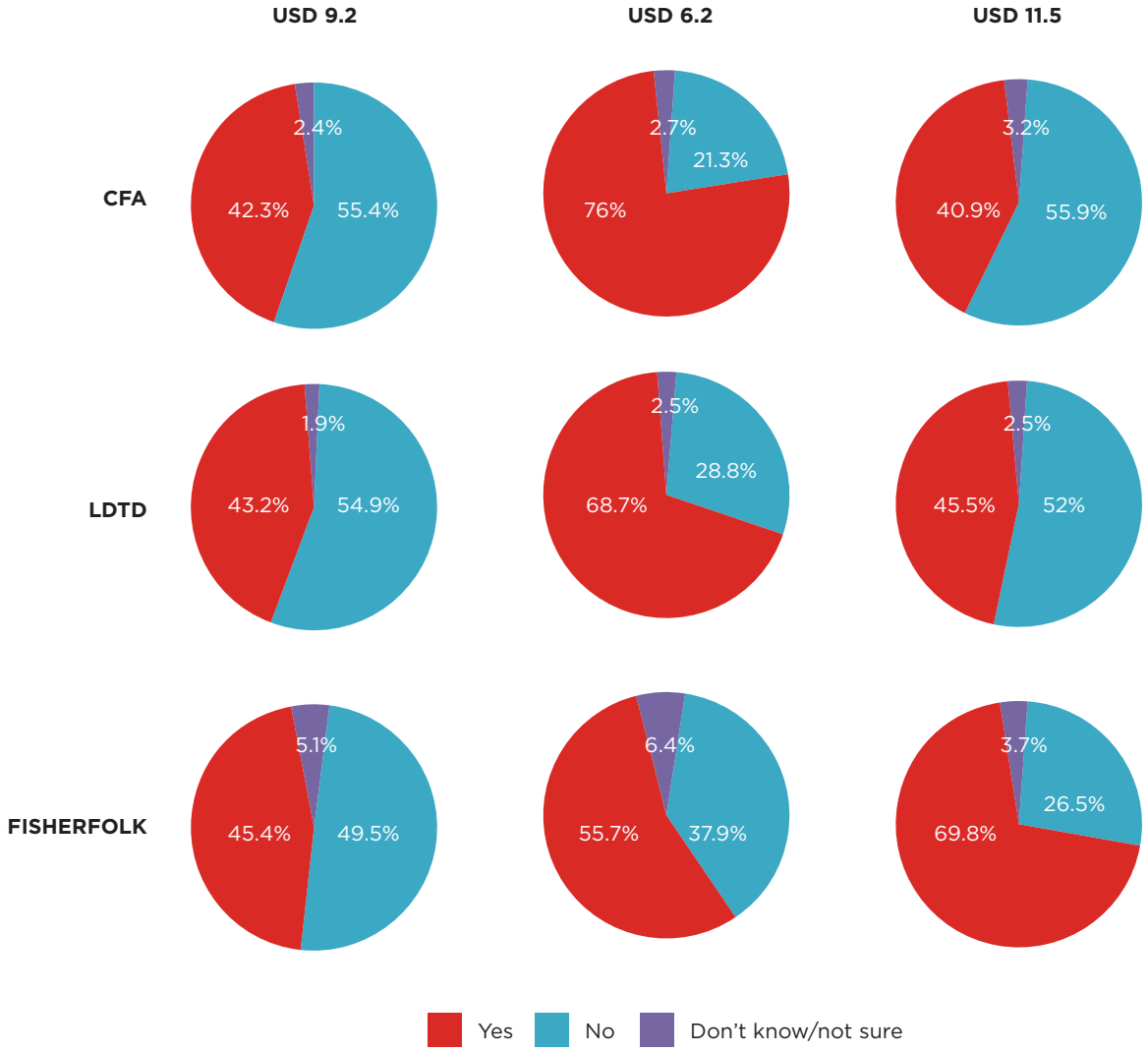
Fisherfolk had lower household income as compared to CFA and LDTD - In terms of ability to pay, average monthly household income varied across cross-border areas and MVPs and was lowest among fisherfolk (USD 38 to USD 108), and higher among CFAs (USD 90 to 424) and LDTDs (USD 115 to USD 422). OOP spending was also
a higher proportion of income for fisherfolk as compared to CFAs and LDTDs.

Few MVP saved for health expenses - Higher income and reporting income met household expenses were factors associated with higher ability to save.



CFA and LDTD had higher willingness to pay than fisherfolk - Willingness to pay the price of USD 9.2 for the model health insurance prototype varied among MVP groups across the three different prices tested for the health insurance prototype and was lowest among fisherfolk (Figure 4). The average maximum amount CFAs and fisherfolk respondents were willing to pay was lower than the price of the prototype (USD 9.2). The maximum amount LDTDs were willing to pay was higher than for the other groups. Overall, 82.2% of MVP respondents were willing to save for healthcare expenses, highest among fisherfolk, but fisherfolk reported being able to save the least as compared to LDTDs and CFAs. The maximum amount respondents were willing to save was higher than the maximum amount respondents reported they were willing to pay for the health insurance prototype. Using a healthcare service in the past year and higher income were factors that increased the WTP and save a higher amount.

Figure 4. Willingness to pay the different insurance prices for the health insurance prototype by MVP



Despite fisherfolk presenting with a higher health need, and 82% reporting the health insurance prototype met their needs, they had the least WTP and also the least ability to pay as compared to LDTDs and CFAs. Therefore, based on ability and WTP, LDTDs would have the highest uptake for a portable health insurance product, whereas a subsidy should be considered for fisherfolk who have a need but do not have the ability to pay.

RECOMMENDATIONS

To facilitate design of viable and sustainable portable healthcare financing products, CB-HIPP suggest the following recommendations.

1. Survey findings can inform design of portable healthcare financing products

Design responsive healthcare financing products that meet consumer characteristics and need: This study provides information on household characteristics including household size, mobility patterns, chronic conditions and healthcare utilization patterns which can support design of healthcare financing products. Information on MVP mobility patterns, access to healthcare during work travel, and reliance on OOP presents an opportunity to add portable benefits that would be of interest to specific populations or to the wider population.

Design sustainable healthcare financing products: Across all respondents, using a healthcare service in the past year and presence of a chronic medical condition were factors that increased the odds of being willing to pay for health insurance. This emphasizes the risk of adverse selection, where those with greater health risks and who are more likely to use benefits tend to purchase health insurance. Adverse selection in turn results in higher costs of claims and contributes to making health insurance unsustainable. In addition, health insurance works best with compulsory membership, with a large number of people with a mix of health risks (healthy and sick) registering. A large pool that represents an average of health risks allows for cross-subsidization, whereby the contributions from all members can be used to pay for the services required to care for those members who are sick. To

overcome the challenge of enrolling large numbers of members with a mix of health risks, there are opportunities to explore partnerships with aggregator organizations such as workers' associations, community-based groups
or through a financial institution or mobile network operator to increase enrollment among groups with ability
to pay.

Healthcare financing products that are subsidized for groups that do not have ability to pay: A way to ensure compulsory membership and participation is to pay for health coverage for those not able to pay. Policy makers should consider subsidies for households with lower ability to pay to improve financial protection and equity in access to healthcare services. This is noted among fisherfolk who present with a higher health need and use, but lower ability to pay among the MVP groups. Subsidies for these groups may be used to pay health insurance premiums or guarantee free access to healthcare services. This will require commitment from governments to increase domestic resources to meet subsidies required for vulnerable communities.

Combine savings and insurance: Based on the concepts tested, respondents were willing to save higher amounts as compared to the amounts they were willing to pay for the health insurance prototype. However, it is unlikely that individuals can save enough to cover all health expenses and particularly for high cost health events, which can easily erode family savings and assets. Blended savings and insurance products where savings can be used to pay for health expenses or to save for insurance premiums can leverage the EAC's high mobile phone penetration to design more efficient and client-friendly products.

2. Develop a regulatory framework for portable healthcare financing

The EAC partner states have regulations and policies for their individual health systems, but none exist to facilitate transnational access and how these services rendered will be paid. There is need for further technical analysis of country regulatory arrangements to identify areas of overlap, similarities and conflict that need to be harmonized at regional level. This will also include additional analysis on immigration data to determine mobility patterns and to map where the need is greatest. Further the EAC should initiate consultations to develop an appropriate legislative framework.

3. Define financing arrangements

The EAC partner states will need to agree on financing arrangements for portable access to healthcare services. Partner states must decide if portable benefits will be provided through existing national mechanisms or if a new mechanism at national or regional level will be designed and developed for this purpose; and commit to resources to operationalize portable access.

4. Harmonize services and standards for service delivery

There is need for consultation and consensus on the package of services to be made available to citizens travelling across borders. In addition, service delivery norms including infrastructure, human resources and guidelines for providing health services must be harmonized and standardized. Once standards have been defined, countries will need to train health workers and ensure sufficient inputs are available to provide the package of services. This will further facilitate design of portable products and ensure access to good quality and effective services.

5. Infrastructure investment to address geographic access

Countries' health systems are at varying levels of capacity and they will need to invest in improved infrastructure and inputs to deliver a basic minimum benefit package. Greater investment in health systems will improve geographic access in the region. As countries develop investment plans, there is an opportunity to use private sector facilities to reduce duplication in infrastructure where possible and target investments where they are needed most.

In conclusion, mobility across the EAC is likely to continue to increase. As such, cross-border healthcare access will grow, and there will be a greater need for healthcare financing products that allow for trans-national access. Information from this study can inform design of healthcare financing products suitable to the needs of EAC citizens and further support the SHP agenda in the region.