Health is Wealth:

How Low-Income People Finance Health Care

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Introduction

There is evidence from all over the world that ill-health is the most common source of vulnerability and shock to household budgets. DFID's International Development Target Strategy Paper (1999) notes, "The case of investing in health has been further strengthened by a growing body of evidence that better health contributes to greater economic security and growth. At the micro-level, better health means less time and expense invested in caring for ill family members, improved physical and intellectual development and higher productivity at work".

There is evidence from all over Africa and specifically from East Africa (particularly Uganda) that low-income people are willing to pay for health insurance (Griffin & Shaw, 1995; McCord, 2000). Only 11.4% of Kenyans have access to health insurance and thus the market for an affordable health insurance product providing appropriate and accessible quality health services is large (Griffin & Shaw, 1995).

While disease and illness are the most important of all the emergencies faced by poor households (see for example Brown and Churchill, 1999 and Wright et al., 1999), the poor are excluded from services offered by most quality health care providers (Bennett et al., 1998 and Musau, 1999). The frequency of ill-health and the limited ability of households to predict whether they will be affected means that health-related risks generate a high degree of uncertainty. Ill-health can have significant effects on the cash-flows of low-income households, particularly women: not only does illness increase costs (consultation fees, medication etc.), but it also means that income earners are often unable to work (either due to ill-health or due to the need to care for sick household members). The disruptions to cash-flow caused by ill-health can have significant impact on the repayment rates of microfinance institutions (MFIs).

The Health Care Financing project seeks to harness the research and product development capabilities of the K-Rep Development Agency, the banking expertise of K-Rep Bank, the experience of AAR Health Services in health care financing, management and provision, and the community-based, low-cost health centres of AAR franchisees. Working together, the consortium members offer important opportunities to capture synergies that will allow its members to develop their businesses while providing one of the most important and sought after services to low-income households in both urban and rural settings.

The project brings together this diverse consortium to develop and test an innovative, private sector-driven, commercially viable and replicable health financing scheme to reach low-income groups comprising four products:

1. franchisee clinics in the urban slums/rural areas and
2. an affordable health care financing (insurance) package for low-income people,

supported by *AAR Health Services*; together with

3. loans to finance the upgrade of franchisee clinics to conform with AAR standards and

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4. loans for the annual membership fees for the health management package, offered by *K-Rep Bank*.

This study was undertaken as the first step in this on-going collaboration designed to develop a low-cost health financing package for low-income people.

Methodology

Extensive background secondary data searches (physical and internet-based) were conducted in order to identify data and ensure that the health financing product would be developed on the basis of the latest thinking/information. Unfortunately, however, little data was available on the urban poor in Nairobi – most epidemiological data was for Nairobi as a whole with little or no social stratification. There was almost no data available on health seeking and financing behaviour.

After a brief quantitative survey, the research team decided to use qualitative tools to get rapid and cost-effective insights into the complex behaviour of low-income people responding to ill-health. This approach allowed the team to examine disease patterns, health seeking behaviour and how low-income people finance their health care needs in a relatively short period of time.

The research was conducted among low-income people in Nairobi slums. To understand low-income people's health needs and health finance/management mechanisms, the research relied mostly on Participatory Rapid Appraisal (PRA) and Focus Group Discussions (FGDs) adapted from the *MicroSave-Africa* approach to "Market Research for MicroFinance". The first author of this report was involved in the development of *MicroSave-Africa's* "Market Research for MicroFinance" tools in Bangladesh, Philippines and Uganda. One of the strengths of PRA and FGD tools is that they can be replicated and used in any sector (health, agriculture, education, finance etc.) with the changes to the relevant variables. The Health Care Financing Project first selected and amended the tools to suit the analysis of health financing needs and then organised training programme for the staff. During that training and field practice the tools were further improved.

Methods of Data Collection

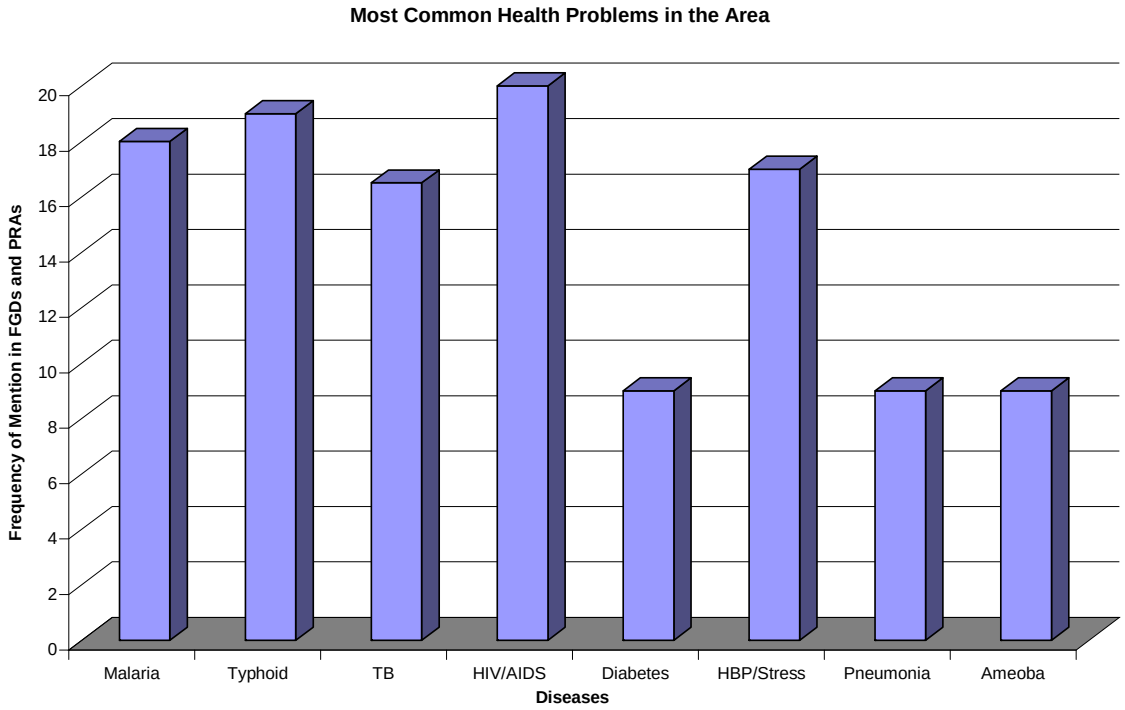
The following tools were used in 40 sessions:

Tool	**# Of Groups**	**#Of Participants**
Focus Group Discussions	12	106
Seasonality of Diseases	4	61
Seasonality of Income, Expenditure, Credit & Savings	3	45
Venn Diagrams of Health Care Service Providers	4	59
Health Care Service Attribute Ranking	4	52
Health Care Seeking Behaviour Maps	3	59
Time Series of Ill Health	2	26
Health Over Life Cycle Profile	2	32
Relative Preference Ranking of Health Care Services	3	35
Detailed Wealth Ranking	3	5
Total	**40**	**480**

Research Findings

Diseases Afflicting The Urban Target Community

Figure 1. Frequency of Occurrence of Common Diseases



As shown in Figure 1, the tally-sheets identified the diseases most commonly mentioned in the FGDs and PRA sessions as HIV/AIDS, typhoid, malaria, high blood pressure/stress/ulcers, tuberculosis, colds, pneumonia, coughs, diabetes and amoeba. Other diseases mentioned included dental problems, eye problems, malnutrition, meningitis, asthma, headaches, joint pains, arthritis, cholera, diarrhoea, Ruai disease (Ruai is the name of an area, in Ruai people often suffer from swollen feet thus respondents mentioned it as Ruai disease), stroke, fibroids etc. In some groups, respondents also mentioned drug addiction, injuries from accidents/robbery, pregnancy, childbirth and other gynaecological problems.

The Health Over Life-Cycle Profile tool was used to identify the phases of health care needs of an individual's life-cycle over time (see Figure 2).

Figure 2. Summary of Health Over Life-Cycle Profile

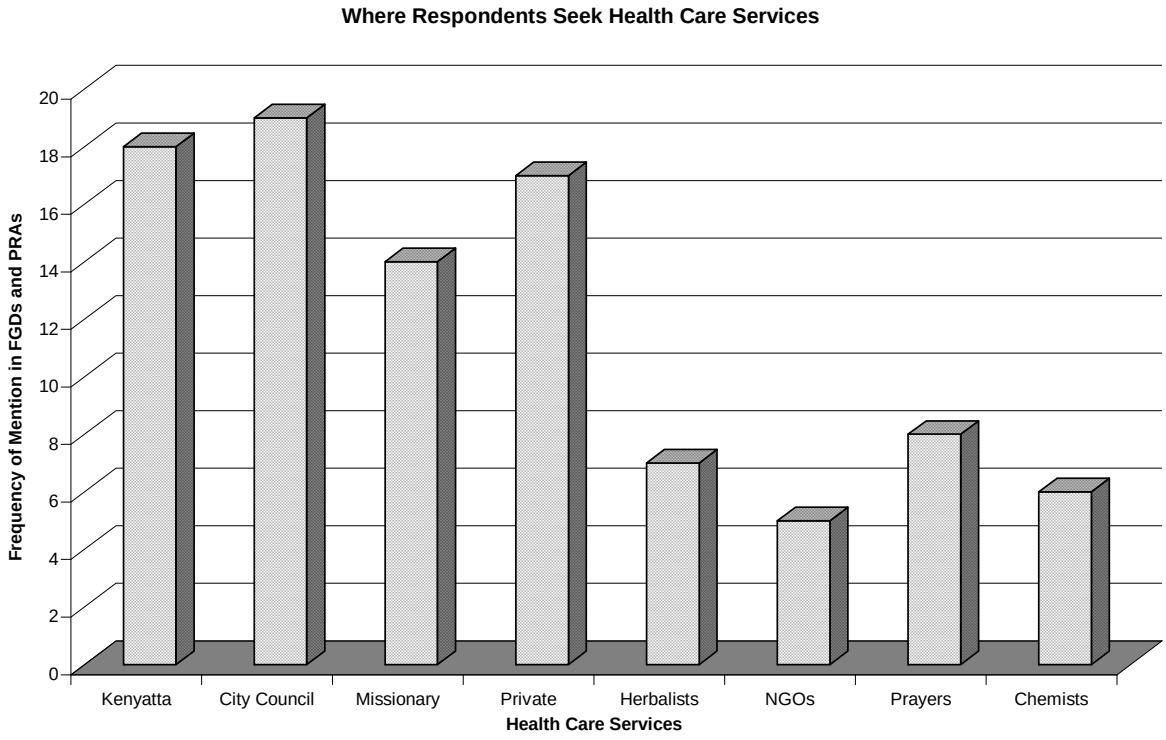
Disease	**0-12 yrs**	**13-17 yrs**	**18-35 yrs**	**36-55 yrs**	**> 55yrs**
AIDS/TB		*	**	*	
Typhoid	*	**	**	*	*
Malaria	**	**	**	**	**
Depression/Stroke/Hypertension			*	**	**
Cancer			*	**	*
Diabetes				**	**
Common colds	*	*			
Pneumonia	**	*			*

HIV/AIDS (particularly associated with TB) was very prevalent in the 18-35 age bracket but was also noted in those 13-17 years and 36-55 years. This disease, for obvious reasons, is regarded as one of the great sources of health and financial problems.

Health Care Seeking Practices in the Target Community

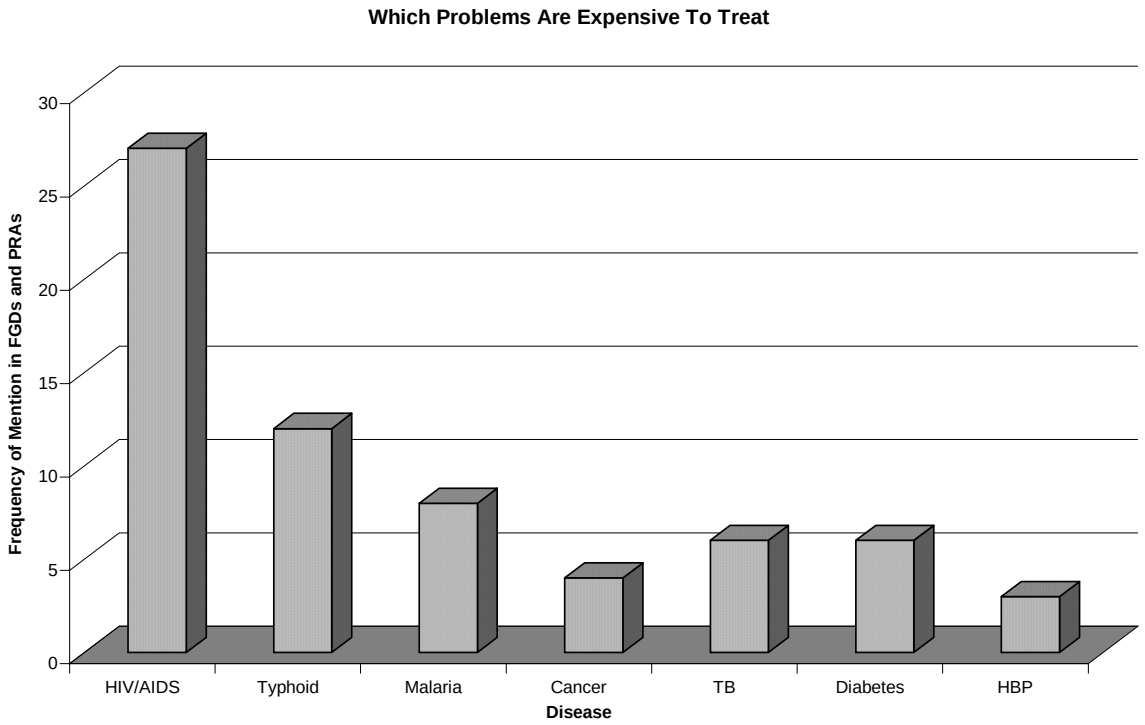
Participants seek health care services from a wide variety of places ranging from government to private owned health facilities. These included city council dispensaries, Kenyatta National Hospital, Missionary/Muslim hospitals, NGOs (World Vision, AMREF etc.) owned hospitals, individual owned private hospitals, chemists, kiosks, herbalists, faith healers, and '*Wagangas*' (traditional/witch doctor). Prayers were also included in the list, often used as a last resort.

Figure 3. Where Respondents Seek Health Care Services



During almost all group discussions, when participants were asked which health problems/diseases cost most for people in the community, they automatically answered in chorus, "*Ukimwi* (AIDS)!", before citing any other disease. But typhoid malaria, TB and others also cost people much money.

Figure 4. Which Problems are Expensive to Treat



The Table 1. below shows reasons given to why the diseases are termed expensive.

Table 1. Why Different Diseases are Expensive

Disease	**Why It Is Expensive**
HIV/AIDS	Incurable, expensive drugs, several opportunistic diseases, expensive diet, patient eats a lot, one cannot work any more, burden to other people
Typhoid	Expensive drugs, difficult to get rid off (it recurs), same symptoms as malaria therefore a patient spends money before knowing that it is typhoid. Because of wrong diagnosis, one spends money twice on medicines.
Malaria	Occurs frequently, affects everybody thus costly as mosquitoes do not choose rich or poor, old or young.
TB	Most times is a manifestation of AIDS thus one does not heal, expensive drugs, it's long-term (6 months of drugs), frequent transport fare to health centre for TB injection

Patients in the health centres noted that some diseases like TB and HIV/AIDS are often not catered for by insurance companies and if not, they would like if they could be made aware of this before hand, "*I have been coming for treatment here for chest problems only to be told later that they do not treat some kind of illnesses… because of my cover*".

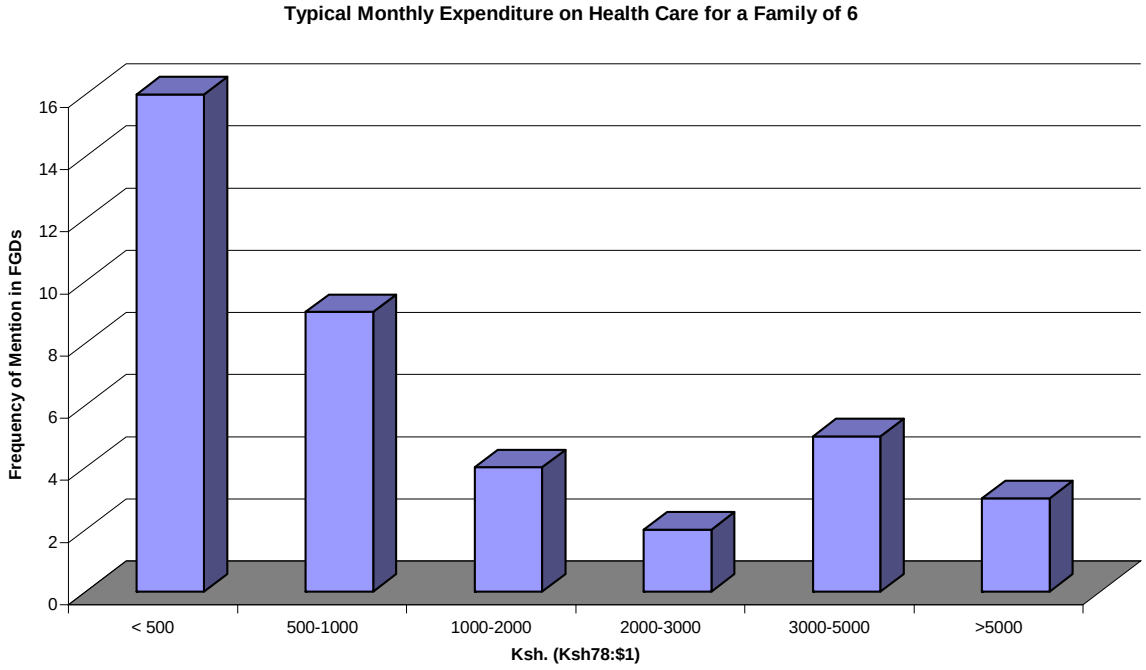
Less expensive health problems were singled out to be colds as it was seen to be something very minor and most often, one does not even need to use any drugs. Participants also mentioned home remedies such as hot lemon, hot steam with herbs etc. for colds. Diarrhoea among children was also seen as cheap since usually the patient only needs Oral Re-hydration Solution to recover.

Stomach aches also cost little as over the counter drugs are available in kiosks. Dental problems were also said to be cheap as they rarely occur and teeth removal was common at affordable rates. Giving birth was also mentioned as cheap as many give birth at home or use traditional birth attendants who are available at low cost in the community.

Finance Options Available for Health Care in the Target Community

Participants were asked on average how much a typical family of six pays for health care in a month in their community. Unlike most other questions, this did not generate immediate, unambiguous response - typically the initial comment was, "it's difficult to know". However, when probed further and asked how much their family spent on health in the previous month, this drew responses as shown in Figure 5.

Figure 5. Typical Monthly Expenditure on Health Care for a Family of 6



The majority of participants said that they spent on average less than Kshs.500 but can sometimes spent up to Kshs.5,000 for a family of 6. A few participants explained that they could spent over Kshs.5,000 or even up to Kshs.10,000 per month. They however explained that the amount of money spent per month depends largely on various things such as the type of illness and one's income and thus preferences. Hospitalisation also played a big role on what amount of money one spends - it might cost Kshs.20,000 per month if one of the family members was hospitalised for approximately two days.

> *"The money you use on health will depend on where you go for treatment. If you go to Aga Khan Hospital or say Nairobi Hospital, you will use a lot of money. But if you go to Dr. Owanga (a health practitioner in Kibera who also works in Kenyatta Hospital), you may use around Kshs.300"*

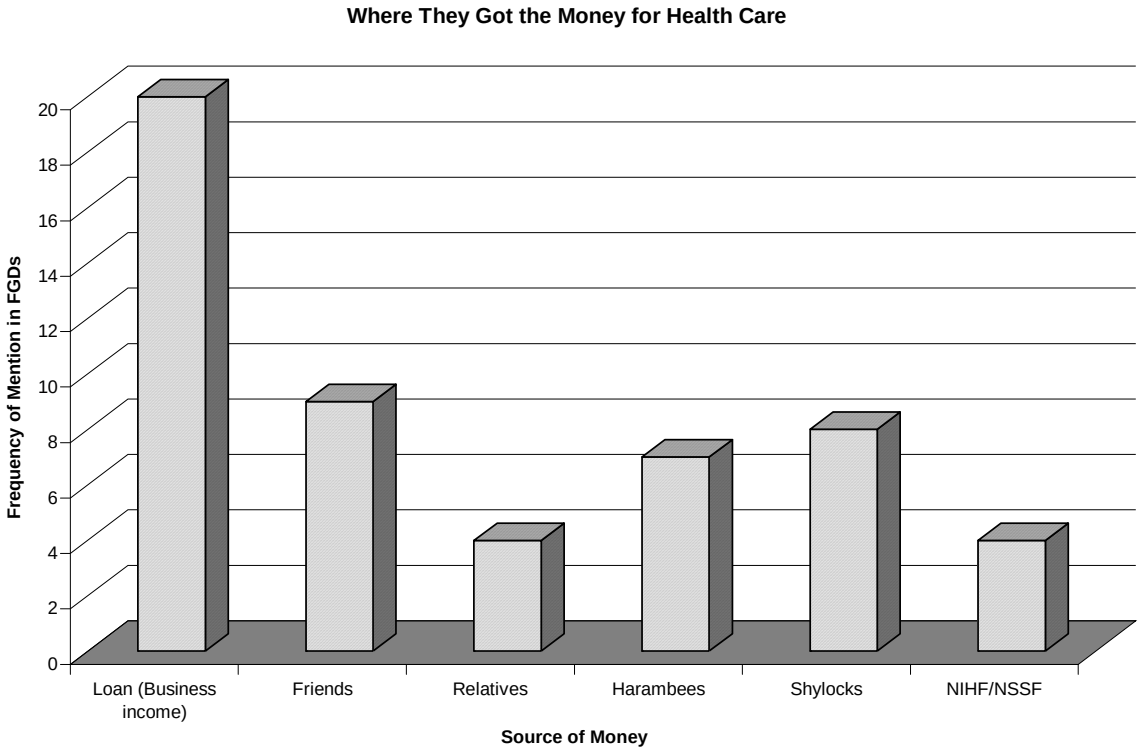
> *"Many times you don't even go to hospital when you are sick. You just buy medicine from the kiosk and you get healed. This will not cost a lot of money, it may only need less than Kshs.100 for malaria tablets."*

Participants also reported that there were months that no money was spent on health care. This mostly applied to those households who do not have young children especially below 5 years of age. One female respondent in Kibera said:

> *"Children are the ones that mostly become sick. So if you are in a house that does not have very young children, a month or even two may pass without anybody becoming sick in the house".*

When disease/sickness occurs, most respondents normally use money from their business income. Sometimes they also borrow from friends and neighbours – this money must usually be returned within a month. Respondents noted that relatives are not a very reliable/effective source as either most will turn you down or they are out of reach, upcountry. Other options are Merry-Go-Rounds, moneylenders ("shylocks") who charge an interest rate of between 25% - 30% per month; selling assets; self-help-groups; and NHIF through employed spouses.

Figure 6. Sources of Financing for Health Care Services



When bills are too high (for example in cases of admission) participants conduct fund raising events (*harambees)*. It was also noted that they are sometimes forced to use their K-Rep "business loan" for health care as sickness is an immediate problem and they always cannot get emergency loans from the K-Rep microfinance group.

K-Rep Bank's Role in Health Care for its Clients

It is apparent from the previous section that K-Rep Bank, through its "business loans" is already playing an important role in financing the health care of its members and their families. It is also clear that this role could be expanded and improved - in almost all groups were asked if K-Rep

could offer health care financing products or services to people in their community, they answered in chorus, "yes!". Participants frequently mentioned that K-Rep should offer an affordable medical insurance scheme to its members with a few conditions and identify good hospitals that they could use. They also stated that K-Rep Bank could:

- Offer affordable medical insurance with less conditions (e.g. compulsory savings) than the business loan,
- Offer emergency loans for health care,
- Pay for it's clients hospital bills and then the client could pay back in small instalments,
- Operate like National Hospital Insurance Fund (NHIF),
- Encourage/develop a system that clients could save for health with K-Rep Bank.

Most respondents had a basic understanding of "health insurance", however, they did not fully understand the detailed implications of it. Participants described health insurance as follows:

> *"When we are in a company like our "Juhudi" group, each member contributes something small to go towards hospital costs such that when one member falls sick, K-Rep pays and when not used it becomes profit to K-Rep. But when sickness occurs, K-Rep pays for the costs".*
>
> *"It's a pre-payment and your hospital costs are met by K-Rep when you fall sick"*
>
> *"When you have problems you are cared for with a premium paid before, just like motor vehicle insurance".*
>
> *"You pay before, even when you don't expect to fall sick. It is only used when one falls sick. It is used in hospitals like Kenyatta and Aga Khan".*

However, participants also felt that many in the community needed explanation of how insurance works, "*Many people here do not understand how insurance works, if you are to initiate such a thing, they should be told. They should not think it is something bad*".

When asked how a "health care scheme" for the low-income groups/people should work, they all agreed that it:

- Should be affordable,
- Should work just like the business loans where one is able to pay in small instalments,
- Or one should be able to pay for it monthly without having been advanced a loan,
- There should be different health care packages for people to choose from, as not all microfinance clients would have same health care needs, and
- Particular health facilities should be identified for health insurance client's use.

Despite the above, participants in one FGD said that they would not be willing to take another insurance as "*our businesses were already insured and we have not seen the benefit*" – this refers to the "loan insurance fees" imposed by K-Rep as part of the business loan package.

Health Care Scheme and Willingness to Pay

Participants were asked how much they could afford to pay (per person) in advance if any organization or health centre offered them a health care scheme. Many respondents suggested that they could afford to pay Kshs.20 - Kshs.100 per week, although the majority of them settled for Kshs.100 per month. Some noted that they could afford within the range of Kshs.200 - Kshs.500 per month. A few of the participants told that they have used the '*Jamii Bora Trust'*, a health insurance scheme run by a charitable Trust, that costs Kshs.1,000 per year for a family of maximum five people but did not mind improvements on the same.

> *"Diseases take a lot of money, especially if you are hospitalized. You may even sell your shamba (land). If we have a medical cover it would really be good."*

> *"Most of us would want to be treated in this good private hospitals (like Aga Khan and Nairobi Hospital) but money is the problem. So, if we can have quality services 'some place' at an affordable rate, it would be good."*

Majority of the participants thought it was a good idea if K-Rep Bank offered loans to pay for the health care scheme but noted that this should be at a lower interest rate, if possible lower than the current business loans. The statement below was from a male respondent whose opinion was common among many:

> *"It is a good idea for K-Rep to offer loans for health. If you become sick and you are admitted, it takes a lot of money …and you know to get that kind of money, I mean borrow money to pay for doctors bill, is very hard. You end up in big debts that you had not expected. So, if K-Rep can help in such cases, it would be very good to us."*

> *"We should also have a medical insurance ... Working people [formally employed] have NHIF. If K-Rep can arrange for us to have one, it would be very good ... However, it should be affordable, you know we are their clients and …and we are helping each other. Even if they get some small profit, we understand as business people."*

> "*…If K-Rep will give us loans for the cover, the interest rate should be low… low than the normal interest they charge us on business loans. You know this is illness and it is not that you brought yourself or you are happy about it, it is a problem*".

It also emerged that people were mostly eager to get assistance for in-patient costs rather than outpatient. However, they settled for getting assistance for both in-patient and outpatient as they explained that both had an effect on their businesses. Getting emergency loans under the health care scheme was also another possibility that participants advocated for. The majority advocated for repaying within a one-year period on a weekly basis (just like the other business loans) or on a monthly basis. Participants suggested that the health care loan repayments should also take place in the K-Rep group meetings or at K-Rep Offices.

> *"We do not want to be 'disturbed' by people on insurance, if we have it, we would like to deal with K-Rep and pay towards the cover just as we do in these groups (business groups)."*

Participants welcomed the idea of saving for health care needs. The majority said that after the sessions had made them consider these issues, they would be willing to start saving immediately, and in fact said that this was overdue: "*it is something that should have been there from the word go*". Few said that they needed more detailed information before starting to save. Also a few expressed their beliefs that saving in advance for health care means, "*inviting diseases*".

Conclusions And Lessons Learnt

It is evident from the research findings that many issues need to be considered when designing a health care scheme. Several important issues were highlighted during the sessions held with respondents. These can be summarised as follows:

1. **Health as a Key Risk:** Low-income people are well aware that ill health is one of the greatest risks and sources of vulnerability they and their households face. On many occasions they have been unable to do their work because of ill health either to oneself, a household member, a relative or even a close friend. They also point out that ill health is very expensive especially when it comes to hospital admissions. Thus they understand that health care is essential as it affects all households. They therefore, are interested to have an affordable health care scheme. ***There is thus a potential market for quality, affordable health-care services.***

2. **The Quality vs. Price Trade-off:** Low-income households have sought treatment from different places, formal to informal health care practitioners. They prefer formal health care service providers but often use informal practitioners, as they are cheaper. However, when seeking treatment for major ailments like HIV/AIDS and typhoid etc. they tend to go to formal health care service providers. Low-income people are, however, willing to pay more for what they perceive as high quality health care services. The consortium thus faces a dilemma since different households will be wiling to pay differing amounts for health care services – and, of course, what is an "affordable" service varies from one household to another. It will therefore be necessary for the consortium to ***develop differentiated schemes of health care services from the low-cost/low cover to the higher cost/higher cover*** with some appropriate *Swahili* names to differentiate and market them. How the schemes are differentiated will require careful examination in collaboration with AAR management, the actuaries and the microinsurance consultant to be hired. Options include:
    a. schemes that cover only in-patient services v. those that cover both in-patient and out-patient services;
    b. schemes that cover some specific diseases; and
    c. schemes differentiated on the basis of the size of the co-payment upon accessing services.

3. **Minor Ailments:** It is important to note that they did not see the point of seeing a health practitioner for such ailments as colds, headaches, sore throat and minor coughs. This provides important indications for setting the level of co-payment. However, it is also important to recognise that some of the symptoms of these "minor" ailments are the same as those for more serious ones that are more tractable with rapid treatment. It is therefore ***important that the co-payment does not result in clients not reporting for treatment early during the course of the disease***.

4. **Special Issues – Children and Seasons:** It was clear that low-income people in the targeted urban communities suffered from diseases that follow specific, seasonal patterns. Children were identified as the ones who suffer mostly from diseases – particularly during the rainy/cold seasons. Children's sickness during cold/rainy season is important to consider when designing the health care package. The key children's diseases in the rainy/cold season are colds, influenza, pneumonia and malaria (typhoid and other diarrhoeal diseases affect children throughout the year) - all relatively tractable with rapid and appropriate treatment. Nonetheless, ***AAR and the health centres should expect noticeable increases in demand for paediatric***

treatment during the rainy/cold season. Hypertension, high blood pressure and related ailments peak round January – primarily as a result of the need to finance school-fees immediately after the high spending that accompanies the Christmas season. The consortium will have to ***examine the desirability of/options for excluding hypertension under one or more of the differentiated schemes*** … or of working with K-Rep Bank to design a savings/loan scheme to assist clients to manage this predictable expense.

5. **Necessity for Education on Insurance:** The target community need to be educated on the nature and role of health insurance since while most people have a rough idea, they did not understand the details or (in many cases) fully understand the idea of paying in advance for services that may, or may not, be used. The users of the health centres had a good perception of the AAR Franchise Health Centres and valued them for their services. However, one dissatisfied client can create much negative publicity against the services - especially in a densely populated community like Kibera. Conversely, of course, it will be important to use "client testimonials" (from satisfied customers who got high-value benefit from their membership) in these densely populated communities. It is therefore important that the consortium ***invest in educating clients on the nature and role of the health care financing scheme***.

6. **Educating Service Providers:** The service providers (i.e. Health Care Financing project staff, MFOs and more senior K-Rep Bank staff, Franchisee Health Centre staff, AAR Marketing Representatives) need ***clear information and training on the exact terms and conditions of the health financing packages before their implementation***. These staff will be key in the marketing of the packages and it is therefore essential that they all understand and market/communicate the packages in the same way so as to minimise confusion amongst the target community.

7. **Demystifying AAR and its Services:** AAR needs more aggressive marketing to inform and persuade low-income communities that the AAR franchisee Health Centres are open to them. AAR is renowned for its high-quality, high-cost services, and it was common among the participants to remark that the AAR Health Centres were very expensive for low-income people. This represents both a challenge and an opportunity. The challenge is to overcome the association of AAR with high-cost services while preserving its reputation for high-quality services. The opportunity is to inform the target community that high-quality AAR health services they know of are now available, at an affordable price, through the health care financing scheme. It should be noted that marketing services to poor people is very different from marketing services to the high-income clients and may therefore require different skill-sets/approaches. The consortium will have to ***take care to design the marketing campaign that emphasises AAR's quality at an affordable price in a manner appropriate for low-income clients***.

8. **Opportunities for Preventive Health Care Education:** Malaria, Typhoid, AIDS occur frequently and these diseases are expensive to treat. If AAR are able to persuade clients to renew health care membership each year (and this has proved to be the major challenge in many other schemes for low-income people) it will rapidly become cost-effective to invest in preventing these diseases. Where such preventive health activities can be targeted specifically to fee-paying members (for example subsidised bed nets or permethrin dip), this can be marketed

as part of the benefits of membership[2]. Other low-cost preventive health activities (for example education of preventing the spread of typhoid and diarrhoeal diseases) can be used as part of the consortium's marketing activities, perhaps in combination with testimonials from satisfied customers (see above). Thus ***preventive health care can be used as an integral part of the marketing activities for the health care financing packages***.

Next Steps: Development and Pilot-Testing of the Product Prototype

This market research report provided the foundation for the development of both an appropriate health care financing product and the marketing efforts to promote it. The consortium combined the expertise of AAR on health care financing with that of K-Rep in working with low-income households in order to develop a sustainable health care financing package for low-income people in Nairobi. Clients join the health care financing scheme by paying an annual membership fee, which gives them access to health services from AAR-accredited franchise health centres. To assist low-income clients to make this lump-sum payment, K-Rep Bank offers specifically tailored loans to finance these membership fees. The payment mechanism for the health financing package was also designed simultaneously with the health care financing package.

The market research report assisted the development of a health care financing package product concept that balanced membership fees with benefits/coverage for the urban low-income community. Thereafter the concept was refined into a prototype health care financing package expressed in clear, concise client-language, using focus groups to whom the concept was presented. These group discussions were also used to assess product names and marketing taglines/benefit statements. After a period of intensive training for service providers and clients, the Health Care Financing project is now pilot testing the prototype urban health care financing package –named by the clients as the "*Afya Card*". The same procedures were followed to develop the urban health loan package, called "*Afya Loan*".

Afya Card

"Usalama wa afya yako"

("Security for your health")

The AAR-K-Rep ***Afya Card*** offers the following benefits to its members:

- It is **EASY:** because primary care is available throughout the membership year: The membership photo-card provides an easy access to quality healthcare in your neighbourhood
- It is **QUALITY:** because services are provided by well trained and experienced AAR staff in a friendly environment
- It is **COMPREHENSIVE:** since it provides both in and out patient services
- It is **AFFORDABLE:** the premiums and terms are designed to accommodate low-income families

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[2] This may be particularly important in the context of people dropping out on the basis that they "got no benefits" from membership because they were not ill during the year.

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