

FACTORS INFLUENCING COMMUNITY HEALTH FINANCING ENTERPRISE SCHEME MEMBERSHIP UPTAKE IN KENYA

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ABSTRACT

Despite the significance of community-based health financing schemes in enabling the poor from marginalized areas to access health care, little effort has been made to study their impact on social protection in the communities where they operate. The study explored how the uptake of scheme membership is influenced by human resource management, social capital networks, access to financial capital, awareness and inclusion of community, and entrepreneurship opportunities. A descriptive research survey was conducted targeting the community-based health financing scheme membership located in Western Kenya. A structured self-administered questionnaire was utilized to collect quantitative and qualitative data, which were then analyzed using SPSS. The study found a strong positive relationship between human resource training and development, social capital networks, access to finance, awareness and inclusion, and entrepreneurship opportunity to facilitate improved livelihoods and scheme membership. These findings informed the recommendations that community health financing schemes should lay greater emphasis on initiating viable livelihood activities for their members to increase their income. In addition, there should be exposure of the members and the scheme management to best practice models for increased performance towards social protection.

Key words: *Community based health financing scheme, social protection, human resource management, social capital network, finance capital access, awareness and participation, entrepreneurship opportunity.*

Introduction

The term community-based health financing has evolved into an umbrella term that covers a wide spectrum of health financing instruments and mechanisms (Hsiao, 2004). Micro-insurance, community health funds, mutual health organizations, rural health insurance, revolving drug funds, community involvement in user fee management have all been loosely referred to as community-based health financing, also popularly referred to as *CBHF*. CBHF refers to any scheme that has the following features: a common objective (e.g. to address unmet health needs and increase financial access to health services), voluntary in nature, and a predominant role of community in mobilizing, pooling, allocating, managing and/or supervising health care resources (Khetrapal, 2004). It further exhibits characteristics of a community's own livelihood mechanism that is applied to access healthcare as part of community's quest for social protection. Health financing refers to the collection of funds from various sources, pooling of funds and spreading of risks across larger population groups, and allocation or use of funds to purchase services from public and private providers of health care (WHO, 2006).

The United Nations Research Institute for Social Development (2010) defines social protection as concerned with preventing, managing, and overcoming situations that adversely affect people's well-being. Health financing scheme membership is predicated on a combination of psycho-socio, socio-economic and cultural dynamics such as geographical proximity, common livelihood activities, religion and participatory initiatives. Members of many health finance schemes are bound together not only by geographic proximity but by shared professional and cultural identity. A narrow geographic definition would exclude many schemes whose members are not geographically linked but rather are members of the same craft, profession, religion, or some other kind of affiliation that facilitates their cooperation for financial protection. The pre-dominance of community action does not mean that community-based health financing mechanisms do not rely on government, donor, or other external support. On the contrary, reviewers of successful community initiatives often point to the role of government and donor support – both financial and non-financial – as a key determinant of sustainability (Carrin, 2004; Atim, 2005). This study has further organized these general factors into 5 areas used as the independent variables, namely human resource capacity, social capital networks, access to financial capital, awareness and inclusion, and entrepreneurship opportunity.

Not much has been studied on CBHF within the East African region beyond the commissioned studies by health insurance organizations such as Micro Save and the HENNET consortium. This realization was the critical incentive to conduct the study.

Materials and Methods

Theoretical and empirical literature review was carried out on the incentives that determine access to mortgage finance towards provision of housing as part of the broader quest for social protection. Sources of literature review were books, journals, dissertations, theses and the web.

A theory is a set of assumptions, propositions, or accepted facts that attempt to provide a plausible or rational explanation of causal relationships among a group of observed phenomena (Thomas, 2007). A theory is usually based upon a hypothesis and backed by evidence. There are several theories and models that have been advanced in relation to the impact of CBHF.

A study by IFAD (2003) identified integrated livelihood mechanisms that poor farming communities have to achieve social protection, illustrated in the sustainable livelihood model. Community based health financing schemes are one such mechanisms now used to access quality healthcare.

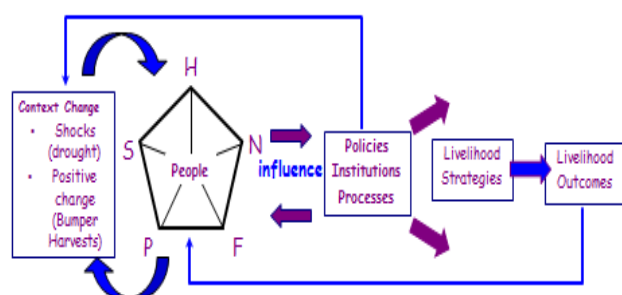


Figure 1. IFAD Sustainable Livelihood Model

Source: (Dorward A., N Poole, J. Morrisson, J. Kydde and I. Urey, 2003).

Human Resource Capacity and Practice

According to Scott A. Snell (1992), there exists a positive relationship between product-market variations and behavior control use, mediated by the presence of managers' knowledge and cause-effect relationship and the crystallization of standards of desirable performance. Studies conducted across 102 firms on behavior viewed within the context of strategic human resource management showed these varied relationships, which are a part of ongoing interrogation and critique for current studies (Varian, 1992). Further to oversight and management of productive human resource, the standard theory of insurance as advanced by Varian (1992) is based on the assumptions that the primary purpose of insurance is to smooth out expenditure on a good for which the need arises unexpectedly. In the case of health insurance the good is health care over a life time. Another assumption is that insurance provides subsidies across people as the particular need may not arise for some people who

pay into the insurance financial pool. The insurance provides risk pooling due to differentiations in risk across time and people (Varian, 1992). This then seeks to spread the fortunes of many across the misfortunes of a few. This theory is supported by Ekman (2004) who focused on community-based health insurance in low-income populations in developing countries. He concluded that community-based health insurance provides some financial protection by reducing out-of-pocket spending. This review indicated that poor families were able to mobilize huge amounts of money to access quality health care due to community based schemes. However, Hanratty et al. (2007), who focused on equity in the use of curative health services, dismissed insurance arguing that it was pro-rich.

Community-based health financing touches on insurance as a way of resource mobilization in order to ensure access to quality health. Community capacity building refers to the identification, strengthening and linking of a community's tangible resources such as local service groups, and intangible resources such as community spirit (Ranson, 2004). A community's definition of capacity may change as the community grows, but it is basically the infrastructure of individual skills and knowledge networks, organizations, businesses that a healthy community is built upon.

Social Capital Influence

Robert Lucas Jr. (1988) advanced the endogenous growth theory of technological advancement, which incorporates a new concept of human capital, skills and knowledge that make workers productive. Unlike physical capital, human capital has increasing rates of return. Endogenous growth theory was satisfied with accounting for empirical regularities in the growth process of developed economies over the last hundred years. As a consequence, it was not able to explain the qualitatively different empirical regularities that characterized the growth process over longer time horizons in both developed and less developed economies (citation). Unified growth theories are endogenous growth theories that are consistent with the entire process of development, and in particular the transition from the epoch of Malthusian stagnation that had characterized most of the process of development to the contemporary era of sustained economic growth. The theory also considers technology improvement, a determinant of quality health. This study argues that community-based health financing facilitates capacity building among members through improved technology.

(Use a more concise summary of this theory and its application).

Awareness, Inclusion and Participation

Equity theory, which best explains and demonstrates social inclusion, attempts to explain relational satisfaction in terms of perceptions of fair/unfair distributions of resources within interpersonal relationships. Considered one of the justice theories, equity theory shows that people value fair treatment which causes them to be motivated to keep the fairness maintained within the relationships of their co-workers in an organization. The structure of equity in the workplace is based on the ratio of inputs to outcomes. Inputs are the

contributions made by the employee for the organization. From the context of this theory, inclusion equalizes opportunity to access quality health services. CHFS have the capacity to include the poor into their schemes/programs, and hence fill in the gap left by inequality (Amrtya, 2006)

Social assistance schemes comprise programs designed to help the most vulnerable individuals (i.e., those with no other means of support such as single parent households, victims of natural disasters or civil conflict, handicapped people, or the destitute poor), households and communities to meet a social floor and improve living standards (Ranson, 2004). These programs consist of all forms of public action, government and non-government, that are designed to transfer resources, either cash or in kind (e.g. food transfers), to eligible vulnerable and deprived persons (Ibid, n. d.). Decentralized theory as advanced by James Edwin Kee (2007) argues that there is need to develop the community from the grassroots. In itself, decentralization refers to the global trend of devolving the responsibilities of centralized governments to regional or local government. The theorist argues that the promise of decentralization is to enhance efficiency and democratic voice. This is participatory planning in development. The decision on how to utilize resources allocated is made by the people in the community, hence use the same on project of their priority. The people at the grassroots get involved in the planning for projects, implementing, monitoring and evaluating them. This provides learning and makes it easy for these very people to hold the providers of services accountable.

Access to Financial Capital

As firms become larger, older, and more transparent with information, their financing options become more attractive. Large firms, as measured by total number of employees, are more likely to use public equity funding or long-term debt as opposed to insider funding (Gregory *et al*, 2005).

Social capital as advanced by Robert Putman (2000) is based on the premise that social capital allows citizens to resolve collective problems more easily. Moreover, social capital greases the wheels that allow communities to advance smoothly. Where people are trusting and trustworthy, and where they are subject to repeated interactions with fellow citizens, everyday business and social transactions are less costly.

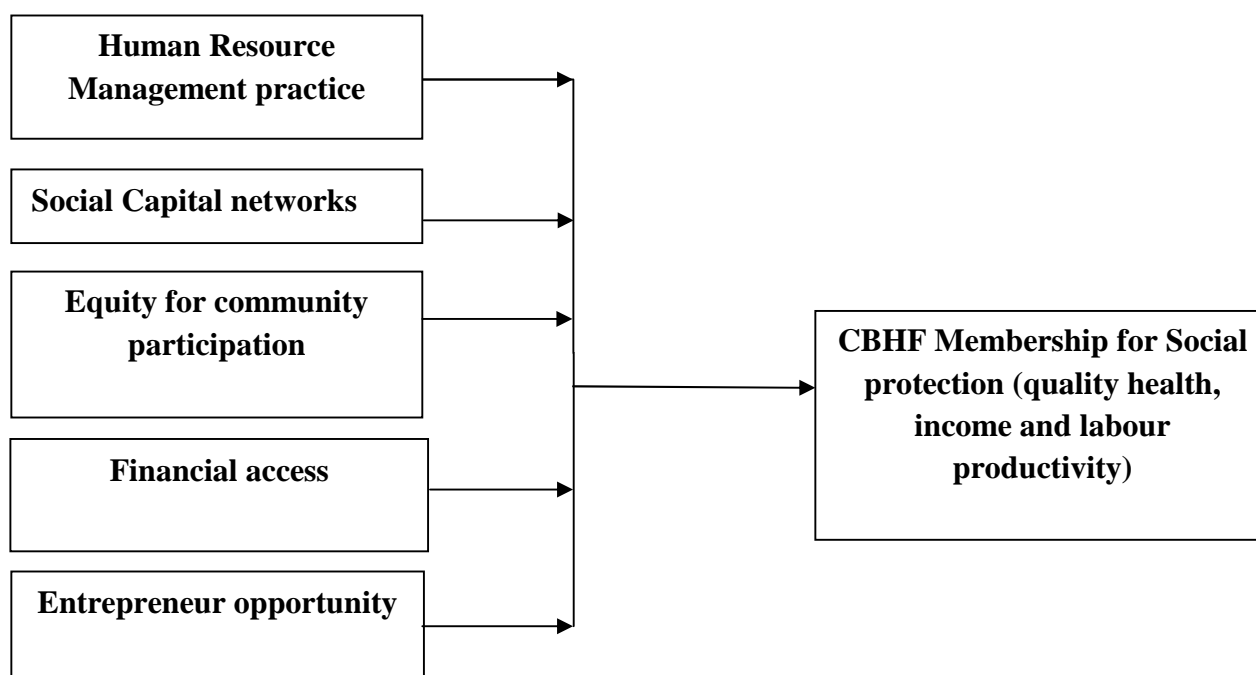
The relevance of this theory to financial protection is related to social capital being considered as 'bonding' (Putman, 2000). In their study on community based health insurance and social capital, Donfouet and Mahieu (2012) found that CBHF scheme mandate is intertwined with the theory of social capital as people from the rural communities are brought together to protect themselves against the cost of illness and improving access to quality health.

Opportunity for Entrepreneur Scheme Members

The Schumpeter economic outcome-based concept that an entrepreneur creates value by carrying out new combinations causing discontinuity is embodied in many of the definitions offered within the last 50 years. There was strong recommendation to adopt Schumpeter's definition for academic, scholarly work and policy-making purposes owing to its wide acceptance. According to Joseph Schumpeter (1927-8), the function of entrepreneurs is to reform or revolutionize the pattern of production. Further, the entrepreneur always searches for change, responds to it, and exploits it as an opportunity (J. Gregory Dees, 1998).

A tentative entrepreneurship theory was formulated by Ivan Bull and Gary E. Willard (1993), extracted from anecdotal observations and extant literature, to better explain and begin to predict the phenomenon of entrepreneurship. The theory stated that 'A person will carry out a new combination, causing discontinuity, under conditions of task related motivation, expertise, expectation of personal gain and a supportive environment'. Proponents argue that CBHF schemes are a potential instrument of protection from the impoverishing effects of health expenditures for low-income populations. It is argued that CBHF schemes are effective in reaching a large number of poor people who would otherwise have no financial protection against the cost of illness (Dror & Jacquier, 2005). The most obvious effect of CBHF schemes is to reduce out-of-pocket expenses for health care. Lower out-of-pocket spending per health seeking event can lead to more frequent utilization of health care services and less delay in seeking care. Further, out-of-pocket health care expenses often constitute a significant percentage of incomes especially for the poor, and often people resort to borrowing.

The conceptualised relationship between the independent and dependent variables is shown in Figure 2.



Independent Variables

Dependent variable

Figure 2: Conceptual Framework

Research Methodology

A descriptive research survey was conducted targeting two schemes located in Busia County, Western Kenya. The sampling frame was drawn from the 2 community schemes selected healthcare providers and contacts in the social service department. The target population was approximated at 15000 people drawn from 2 locations.

Our study population was 371 members within 2 schemes which provided a viable sample size of 188. Structured self-administered questionnaires were piloted and refined and then utilized to collect quantitative and qualitative data. Out of 188 questionnaires issued, 144 were returned duly administered, giving a 77% response rate. The data was then cleaned, collated and analyzed using statistical package for social science – SPSS application.

Results and Discussion

From the responses, 77.08% had attained tertiary level education, dispelling what had been earlier thought that scheme membership was mainly semi – literate. On the statements under each of the variables, 80.6% of the respondents agreed that proper human resource practice enhanced scheme membership uptake owing to a more effectively run scheme, 62.5% felt that social capital networks enhanced uptake of scheme membership and hence improved access to health and social support, 75.2% felt that access to financial capital had a great influence on scheme membership uptake, 57.1% agreed that awareness, inclusion and participation influenced scheme membership uptake where many felt they belong and could benefit from their contribution in ideas and money, but also benefit from the current devolution process in the country. From the responses, 89 % of the respondents indicated that membership uptake is also influenced by opportunity for enterprise for existing and prospective scheme members.

The corresponding mean for human resource capacity influence was 3.96 and standard deviation 1.2, mean generated by responses on social capital networks, awareness and inclusion at 3.83 and standard deviation of 1.1, influence of access to finance with a mean of 3.82 and a standard deviation 1.1, entrepreneurship opportunity by a mean of 3.83 and standard deviation of 1.1. All the identified variables had a positive influence.

Both the analysis of variance and the step-wise regression were performed, where the value of significance determined was 0.02 and the F Calculated was 6.66, which showed that the overall model was significant.

The regression model also helped determine the P – value for each of the selected variables using both the unstandardized and the standardized coefficients given as follows;

$$Y = 3.434 + 0.207(x_1) + 0.293(x_2) + 0.178(x_3) + 0.128(x_4)$$

Where Y represents uptake of CBHF scheme membership for social protection

X1 = HRM capacity and practice; p – value of 0.0402

X2 = Social Capital Networks; p – value of 0.0116

X3 = Access to Financial capital; p – value of 0.0304

X4 = inclusion and participation; p – value of 0.0419

X5 = entrepreneurship opportunity; p – value of 0.0016

The analysis gave a p value for the variable x5 (entrepreneurship opportunity) as 0.001567, putting it as the least on the scale. This then implied that the most significant variable at predicting membership uptake of the community scheme was opportunity for entrepreneurship or ‘enhanced livelihood activities’ in the form of viable income generating activities.

Data findings revealed that the quality of training and development towards HRM within schemes is highly linked to the overall CBHF scheme performance and quality of membership as shown by a mean of 4.01 and a standard deviation of 0.78; that vacant higher technical and problem solving positions are exclusively filled from outside the scheme as shown by a mean of 3.97 and a standard deviation of 0.85; that the form of training offered includes mentoring, management and supervisory development, and CBHF operations exposure as shown by a mean of 3.92 and a standard deviation of 0.95. This is in line with study findings by the Ontario Healthy Communities Coalition(2013), that a community must recognize its social capital to build its capacity and it also needs to build capacity to effectively use and develop its social capital.

The study also found out that Social assistance schemes towards social capital comprise programs designed to help the most vulnerable individuals as shown by a mean of 4.13 and a standard deviation of 0.68; that health insurance schemes are a popular way reducing risk in the event of shock as shown by a mean of 4.03 and a standard deviation of 1.15; that in risk-sharing schemes, the insurance premium is unrelated to the likelihood that the beneficiary will fall ill and benefits are provided on the basis of need as shown by a mean of 3.80 and a standard deviation of 1.44; that individuals with low income may not be able to afford insurance as shown by a mean of 3.75 and a standard deviation of 1.18; that insurance schemes should be complemented with social assistance as shown by a mean of 3.57 and a standard deviation of 1.47 and that social insurance schemes protect beneficiaries from catastrophic expenses in exchange for regular payments of premiums as shown by a mean of 3.56 and a standard deviation of 1.08-implying that these study findings support studies by Jutting (2005) on community-based health insurance scheme and its contribution to improvement of health access by poor people in Senegal.

Findings also revealed that respondents agreed that entrepreneurs and the enterprise / business opportunities should lead to community economic development which ‘calls for

citizens to shape their local economies by influencing the type of business, industry, and employment opportunities in their own backyards as shown by a mean of 4.29 and a standard deviation of 0.9; that there has been a shift in preference from a more controlled, state-led approach to more de-regulated market - driven approaches as shown by a mean of 4.25 and a standard deviation of 0.8 entrepreneurs gain networks, synergy and competitive advantage through CBHFs and hence are assured of enterprise growth social as shown by a mean of 3.92 and a standard deviation of 1.9; and that entrepreneur opportunity and access to markets for CBHF members' products and services are important as the members of the community are able to make CBHFs an effective avenue for improved business as shown by a mean of 3.56 and a standard deviation of 1.1, a slight departure from the earlier Keynesian models but consistent with Schumpeter (1927-8) who opined that the function of entrepreneurs is to reform or revolutionize the pattern of production, but also upheld that the entrepreneur always searches for change, responds to it, and exploits it as an opportunity (J. Gregory Dees, 1998).

The analysis of five (5) independent variables studied explains only 74.5% of the variations in Community uptake of CBHF for social protection; as represented by the R^2 . This therefore means that other factors not studied in this research contribute 25.5% of the variation in Community uptake of CBHF for social protection. Therefore, further research should be conducted to investigate the other factors (25.5%) that influenced Community uptake of CBHF for social protection.

Conclusions

From the findings, the quality of training and development is highly linked to the overall CBHF performance, which makes a good case to encourage exposure to best practice for schemes. The study also concludes that social assistance schemes comprise programs designed to help the most vulnerable individuals; that health insurance schemes are a popular way of reducing risk in the event of shock; that in risk-sharing schemes, the insurance premium is unrelated to the likelihood that the beneficiary will fall ill and benefits are provided on the basis of need; that individuals with low income may not be able to afford insurance.

Community Based Health Financing schemes are a potential instrument of protection from the impoverishing effects of health expenditures for low-income populations; that CBHF is an emerging concept for providing financial protection against the cost of illness and improving access to quality health services for low-income earners; that community-based health insurance provides some financial protection by reducing out-of-pocket spending. Entrepreneurs in the rural remote zones are a valuable resource and can influence livelihoods and offer critical solutions for government and other actors. The enterprise and business opportunities should lead to community economic development which 'calls for citizens to shape their local economies by influencing the type of business, industry, and employment opportunities in their own backyards.

Community based health financing schemes are worth taking up as an instrument to expedite social development within devolved units, given the schemes provide a ready platform for citizens to engage and utilize state funds for viable livelihood projects.

The schemes are also a practical and comparatively inclusive process for providing financial protection against the cost of illness and improving access to quality health services for low-income earners, and also provide some financial protection by reducing out-of-pocket spending that often constitutes a significant percentage of incomes for the poor, making them resort to borrowing.

The study established only a possible 74.5% of the factors that influence entrepreneur uptake of CBHF for social protection in Western Kenya. Further research is needed to establish the other 25.5% of the determinants. Also, there is need to establish how effective the CBHF model can be as a platform for community-led social enterprise, where entrepreneurs within remote rural and marginalized communities can be rallied to offer solutions to the unique problems within their neighborhoods and spearhead innovations in a fast tracked approach. There is also need to conduct similar studies in the other regions to establish if the same findings hold.

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