Healthcare Financing For the Aging Population in Kenya

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Abstract: **Universal Health care and strengthening health equity for the ageing population is one of the top policy priorities of the Government of Kenya. Although an aging population is the positive result of social progress, economic development, health care improvement, it makes challenges to the growth of economies as the shortage of labor resource, rising health cost, social security, impact on savings, investment, consumption, shifting migration flows. The purpose of this study is to assess the universal health care needs for the aging population. Specifically, the study sought to examine the status of healthcare financing population among the aging population in Kanduyi Sub-county, Drawing from the Social Disengagement and Activity Theories, this study provided empirical evidence healthcare financing influence on the wellbeing of the aging population. Mixed method approach will be adopted. The target population of the study were elderly citizens of aged sixty five (65) years and above. The total sample comprised 385 respondents with a mean response rate of 95%. Data was collected through questionnaires. The results revealed most of the aging population in lacked health financing plan and medical insurance. The study demonstrated that the majority of respondents 60% had did not get health care financing form the government. The result shows that source of financial support, managing bills, source of care, medication and mode of transport and characteristics like income, size and headship commonly influence healthcare expenditure. The finding of the study provide recommendations for policy implication as the rights of aging persons are anchored in the Constitution of Kenya, Article 57, and hence the need for a policy and legislation that facilitates enjoyment of these rights**

I. INTRODUCTION

1.0 Background

The financing of healthcare services for the ageing population has been of a major concern to all governments in the face of increasing healthcare costs. Population ageing has become the demographic challenge of globalization. Based on the recognition of the role and rights of older adults, the World Health Organization (WHO) launched the Active Ageing Policy Framework in 1999. The WHO defines active ageing as the ability to participate in society while having basic needs met; this definition emphasizes maintaining a good quality of life as long as possible after reaching old age (Wang 2003). Recently, many countries have proposed some theoretical and practical policy initiatives to solve the problems associated with a rapidly aging population, including Healthy Aging, Active Aging and Aging in Place (Coley et al., n.d.; Davidson, 2013; Schafer et al., 2008).Countries in the world are experiencing growth in the number and proportion of older persons aged 60 years and above in their population. In 2015 there were 901 million women and men aged 60 and above worldwide. This figure is projected to reach 1.4 billion by 2030 (UN, 2015).

According to the United Nation, the 21stcentury is the aging population century. Accounting for over 67% of the total of more than 900 million old person are living in the developing economies. Even the least developed economies are also facing this problem. According to the World Bank the aging population will impact strongly on economic growth, human resources, employment, social security, health and sustainable development(Chappell, Crc, & Chappell, 2009; McPake & Mahal, 2017).

Sub-Saharan Africa is facing an expanding ageing population attributed to improved medical care, improved diet and nutrition, as well as general wellbeing. While the developed countries have made great strides toward assuring the security for their older populations and legislated their rights in sub-Saharan Africa little effort has been made. Yet Africa is the continent most affected by poverty, conflict, environmental challenges as well as poor access to health care. All are critical for improving quality of life, especially for older people. The continent has to contend with additional challenges such as increasing budget constraints. This is making it hard for countries in the region to achieve goals set out for ageing populations such as those in the Madrid Plan of Action on Ageing. These plan seeks to ensure countries look after the elderly by respecting their rights, eradicating poverty, and empowering them to participate in society(Costa & Jongen, 2010; Schafer et al., 2008; Xie et al., 2016).

The increase in the number of elderly people has led to increased pressure on the public sector for long term care financing (Reinhardt, 2003). Latest statistics from healthcare system in UK indicates and an annual cost increase of between 0.48 to 1.12 as result of a growing ageing population (Caley and Sidhu, 2011). Notwithstanding, anecdotal evidence indicate that age is insignificantly related to healthcare expenditure controlling for death (Zweifel et al., 1999; Zweifel etal., 2004).

Studies from different parts of the world suggest significant reductions in the disability and mortality of seniors and an increase of general well-being (Manton and Gu, 2001; Kalediene and Macijauskiene,2013;Steptoeetal.,2015). There is a great deal of evidence showing that seniors are the main

users of healthcare services and they also consume a disproportionally larger amount of all prescribed drugs (World Health Organization, 1999; Department of Statistics of Lithuania, 2005; Maher et al., 2014; Sganga et al., 2015).

The growth of the elderly population is also accelerating in the developing countries including Kenya and it is projected that these countries collectively will account for 6.3 percent of the global population aged 60 years or over in 2030 (UN, 2011). The growing number of older persons raises questions about their wellbeing in terms of economic security in old age, social support, healthcare, and living conditions. It is therefore important that the government puts in place policies that will target the needs of the older persons. In order to achieve the ultimate goal of Universal health care the Government of Kenya has developed a policy framework, under the Big 4 national agenda which includes reducing the risk factors associated with non-communicable diseases and functional decline as individual age, while increasing factors that protect health, in which nutrition and health care are important factors. In Kenya, this emerging area of health has set the pace for discussions on how to care for an ageing population. To date, Kenya has no long-term care public insurance scheme for older people and access to private health insurance is very limited. Older people are expected to receive health care at government hospitals and no special provision or arrangements are in place. A lack of doctors specializing in geriatric care further compounds the problem. Care of older people with disabilities and chronic health problems is mainly undertaken by family members and only about 16 facilities for residential care are available in the country. Most are run by religious organizations. There is therefore substantial unmet need for both long- and short-term care for older people in Kenya.

Unfortunately, many countries in the East Africa region rely extensively on social health insurance financing for healthcare payments. However, there has been limited evidence-based in-depth analysis to examine healthcare financing issues related to the aging population. This is the important gap that this study intends to fill. The study therefore sought to examine the framework for universal healthcare financing for the aging population in Kanduyi Sub-County, Kenya.

II. METHODOLOGY

The study used employed quantitative approach. The quantitative methodology involved using a structured questionnaire, desk review of secondary data from the 2019 Kenya Population and Housing Census, the 2014 Kenya Demographic and Health Survey (KDHS), and the 2014 Economic Survey. These sources were used to generate information on population, health and economic issues at both sub-county and ward levels. It presented a synopsis of the demographic and socioeconomic characteristics of the sub-county and each of the wards. The target population of the study was 385 elderly citizens of Kenya both male and female aged sixty five (65) years who reside in Kanduyi sub-County. The quantitative methodology also involved the generation of population projection data for each of the counties using PADIS software. The survey utilized a two-stage cluster sampling design. The first stage of the sampling process involved selecting sample points (clusters) from a national master frame maintained by the Kenya National Bureau of Statistics. The list of enumeration areas covered in the 2019 Kenya Population and Housing Census constituted the frame for project sample selection. The second stage of selection involved the systematic sampling of households from a list of households in the selected clusters. The sample for the project was sub-county in scope covering the 8 wards in Kanduyi Constituency in Kenya. These wards were clustered into 8 survey regions based on social-demographic characteristics. In mapping out areas where the data was collected from, the survey was guided by the National Sample Survey and Evaluation Programme (NASSEP V) which is developed and managed by the Kenya National Bureau of Statistics. Each tool was administered to targeted respondents who had been determined using criteria that had been set prior to the survey field work. The criteria used to recruit those who would participate in age, gender and access to UHC.

Questionnaire was the key research instruments for data collection. The instruments were developed based on reviewed literature and contained section relevant to the specific objects of the study and were used to solicit information on the key issues affecting the wellbeing and participation of old people in terms of health, economic opportunities, psycho-social and nutritional health care needs. In addition to this, the tools were used to collect information on how the identified issues could be addressed. The survey pre-test was conducted in October 2019, where five (5) project team members and a selection of research assistants participated. The purpose of the pre-test was to check on the flow and meaning of questions, language used in the tools, and the time it would take to administer each tool. The quantitative data was processed using SPSS and PADIS. Descriptive and inferential statistics was used to analyze the data gathered for the study. Specifically, SPSS software was used to compute the frequencies means and standard deviations, and Analysis of Variance (ANOVA) establish the prevalence and variations in health care finance in the context of age, gender and rural-urban residence.

III. RESULTS AND DISCUSSION

The study sought to examine the framework for universal healthcare financing for the aging population in Kanduyi Sub-County. To achieve this objective, the respondents were asked to respond on the questions asked to them in regard to health care financing and the findings were as discussed below.

3.1.1 Financial Support from Government

Table 3.1: Financial Support from the government

Statement		Count	% Count	Chi-square test of goodness of fit		
				Chi-Square	df	p-value
Do you get financial	Yes	145	40%	14.680	1	0.00 < 0.05

support from government?	No	218	60%			
	Total	363	100%			

Most of the aging population in Kanduyi sub-county seem not to be accessing the finances released by government to support the elderly people in the region as indicated by a significant majority of the respondents, 60% [$x^2(1)$= 38.399, $p - value$ = 0.000 < 0.05] as shown in Table 3.14.

3.1.2. Managing medical bills among the aging population

The study sought to determine how the aging population is managing to pay medical bills and how it relates to the amount they spent to the medical bills, the findings were as shown in Figure 1 and Table 3.15 below.

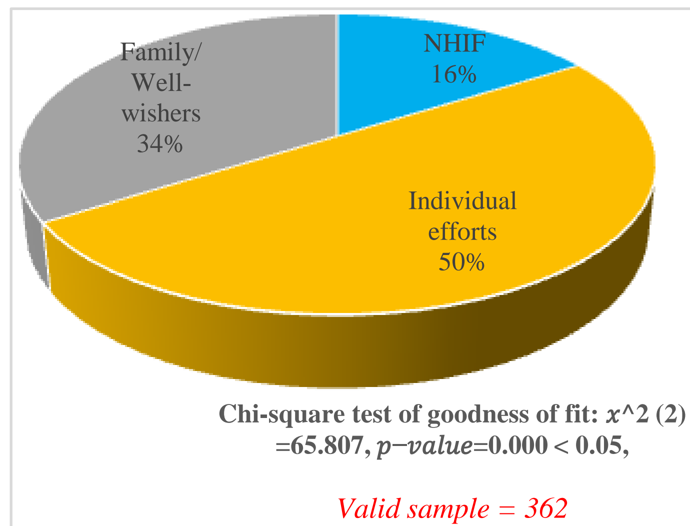

Figure 10: How the elderly people in Kanduyi Sub-county make to settle their medical bills

Majority of the respondents, 50% settle medical bills from their pockets, 34% are helped by their family members and other well-wishers and only 16% are accessible to NHIF for medical bills. The Chi-square results [$x^2(2)$= 65.807, $p - value$ = 0.000 < 0.05] are significant, indicating that the proportions are significantly different from each other, and therefore, the study concludes that most of the elderly people in Kanduyi sub-county seem not to be enrolled on NHIF instead depends on individual efforts cover medical expenses.

Table 3.15: Managing medical bills among the aging population

Statement		Sources for medical bill payments				Chi-square test of independence		
		NHIF	From my pocket	Family/ Well - wishers	Total	Statistic	df	p-value
Amount spend on medical bills per month	Nothing	9	0	0	9(3%)	61.649[a]	6	0.000< 0.05
	Below 1000	22	64	50	136(42%)			
	1000 - 5000	14	97	55	166(51%)			
	Above 5000	4	9	2	15(5%)			
	Total	49	170	107	326(100%)			

Most of the aging population in Kanduyi sub-county seem to be spending between Ksh. 1000 to Ksh. 5000 every month on medical bills as indicated by majority of the respondents, 51%. All those aging population who are enrolled on NHIF do not spend on medical bills every month while majority of those paying for medication every month are not enrolled on NHIF. The chi-square test of independence results, [$x^2(1)$ = 61.649, $p - value$ = 0.000 < 0.05] show a significant association between amount of money paid towards medication and source of payments; this indicates that those on the NHIF are likely to spend nothing whenever they go for medication in hospital. Most of the aging population in Kanduyi Sub-county have not realized the importance of enrolling for NHIF to help them plan effectively for their medication so that they don't straggle to raise money to pay bills whenever they're in hospitals. The government should therefore sensitize and encourage the aging population and their next of keens to enroll NHIF for medication.

3.6.3. Source of care for the sick aging population

The study sought to determine who are the people taking care of the elderly people in the society and the findings were as shown in Table 3.16 below.

Table 3.16: Care for the Sick Elderly people

Statement		Valid count	% valid count	Chi-square test of goodness of fit		
				Chi-Square	df	p-value
Who takes care of you when you're sick?	Myself	18	5%	546.117	2	0.00 < 0.05
	Family members	329	91%			
	Well-wishers	13	4%			
	Total	360	100%			

Most of the aging population in Kanduyi sub-county in most cases are taken care of by their family members (children, grandchildren and relatives) when sick as indicated by a significant majority of the respondents, 91% [$x^2(2)$ = 546.117, $p - value$ = 0.000 < 0.05] as shown in Table 3.16. However, a few aging population seem to be taking care of themselves when sick with no one to look after them as indicated by 5% of the responses.

Table 3.17: Health care among the aging population

Statement		Whom do you stay with?			Chi-square test of independence		
		Alone	Family	Total	Chi-Square	df	p-value
Who takes care of you when sick?	Myself	14	3	17	40.834	2	0.00 < 0.05
	Family members	7	320	327			
	Well-wishers	3	10	13			
	Total	24	333	357			

Most of the elderly people that stay alone seem to be taking care of themselves when they fall sick as indicated by majority of the a majority of the respondents, 14 out of 24 respondents. The chi-square test of independence results, [x^2(2)= 40.834, $p - value$ = 0.000 < 0.05] show a significant association between who takes care of aging population when sick and when normal condition; this indicates that those aging population living alone in the homestead tend to suffer alone and take care of themselves when sick. Most of the aging population in Kanduyi Sub-county who stay alone seem to be having difficulties when sick as most of them are the ones to take care of themselves without assistance from someone else. The government should find a way to take care of the lonely aged population so that they don't suffer alone in silence when sick.

3.6.4. Source of medication and mode of transport to hospitals among the aging population

The study sought to determine where the aging population access their medication most of the times when sick and what mode of transportation they use to hospitals. The findings were as shown in table below.

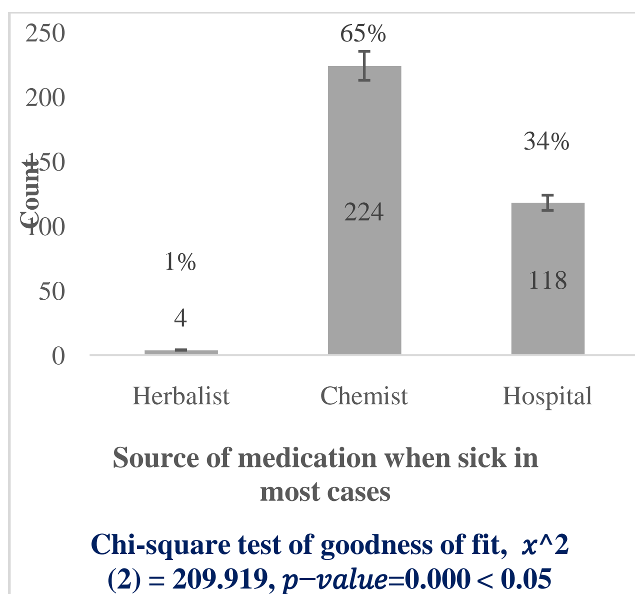

Figure 11. Source of medication for the aging people

Most of the aging population prefer getting medication from chemists as indicated by a significant majority of the respondents, 65% as shown by non-overlapping error bars (see figure 11). A few of them seem to consider hospital most of the times they are sick as indicated by 34% of the respondents. The chi-square test of goodness of fit [x^2(2)= 209.919, $p - value$ = 0.000 < 0.05] was significant, an indication that the responses across the three categories were significantly different from each other. This indicates that most of aging people in Kanduyi sub-county prefer taking medication in chemists than in hospitals.

The respondents were also asked to indicate the mode of transportation they normally use to go to hospitals and the findings were as shown in Table 3.18.

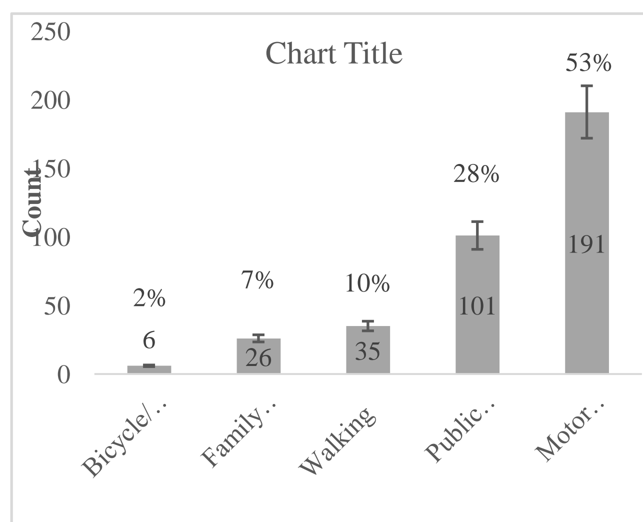

Figure 12: Modes of transportation to hospitals among the elderly people

From the findings of Figure 12, it is evident that majority of the aging population prefer use of motor bicycles and public vehicles as means of transportation to the hospitals in most of their sickness conditions as indicated by a significant majority of the respondents, 53% and 28% respectively as indicated by the non-overlapping error bars. However, a significant proportion of the respondents, 10% (significantly indicated by the non-overlapping error bar from x-axis) used to walk on foot to hospital in most cases of sickness that required hospital; this indicates that there are some aging population in Kanduyi sub-county that walk to hospitals for medication regardless of their age and distance involved.

V. CONCLUSION AND RECOMMENDATION

5.1 Conclusion

The study concludes that the issues affecting older members of society in the country are increasingly becoming critical owing to the changing demographics and population projections. The following conclusions are drawn from the study. Most of the aging population in Kanduyi Sub-county lack health financing plan and medical insurance. There is need to advocate for the free medical care initiative, financial

support and food supply as effective measures the government can use in improving the health needs of the elderly as indicated by a significant majority of the respondents.

5.2 Recommendations

a. Develop and continually improve the system health financing infrastructure through appropriate legislation and sustainable financing mechanisms that enable access to services.
b. There is need to conduct continuous public education through National Social Security Fund and the National Health Insurance Fund for mandatory and comprehensive implementation of the national health insurance and the national social security scheme particularly in the rural areas to cushion the population during their old age and retirement in financing their medical expenses.
c. The County Government to work closely with the national government in ensuring complementarity and up scaling of the social protection programmes namely the food programme and the cash transfer for the older members of society to reach higher population of the older members of society.
d. Sustain monitoring and support systems by maintaining engagement with community members, community groups and other services in the delivery of health and social care services.
e. Make available the infrastructure (e.g. physical space, transport, telecommunications) that is needed to support safe and effective care delivery in the community.
f. Deliver care (with assistive products when needed) that is acceptable to older people and targets functional ability.
g. Modify policies and processes to structure financing for health and social care services around a shared or pooled funding model that includes financial incentives for appropriate care coordination at the service level and includes the cost of interventions and essential medicines and devices to maintain intrinsic capacity (IC) and functional ability

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