Modalities of Healthcare Payment and their Consequences – A Qualitative Study on Kenyan Doctors

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Abstract

Introduction: The Kenyan government has put a spirited reform to ensure all Kenyans get universal healthcare. This has led to restructuring of several entities among them the health insurance industry. This is geared at alleviating the burden of catastrophic expenditure on health from the poor Kenyans. However, insurance uptake remains at less than a quarter of the population with many Kenyans still paying for healthcare out-of-pocket. These out-of-pocket payers often don't afford the ever-increasing cost of healthcare in Kenya. This study looked at how doctors deal with patients given their modality of payment.

Methodology: This was an online based survey that was distributed to Kenyan doctors via email by Kenya Medical Association. The survey sought information from the respondents on how they dealt with patients given their modality of payment. In addition, respondents were asked to provide an example of a case they had dealt with that touched on each payment modality.

Results: Respondents gave their experiences where insurance had influenced their clinical decisions. Codes developed from the prose were; "inability to pay", "harmful to the patient", "changed the prescription" among others

Health insurance played a crucial role whenever respondents made decisions. Top on the list of things that the majority indicated would be considered is insurance status and/or their ability of patients to pay for the services.

Conclusion:

Respondents are stuck in a limbo; striving to give the best care to patients but limited by the patients' inability to pay. In explaining their experiences, respondents explain a situation where they intend to offer the best, but patients cannot afford. This especially so for those without health insurance who end up either not getting services or at the very best, get inferior services

Keywords: Health insurance, Emergency medical care, Clinical decisions

1) Introduction

Kenya, in compliance with the global requirement to improve healthcare has made health one of its four major projects. The emphasis is to achieve universal health care (UHC) by 2022. While applauding the decision and efforts made by the government, the achievement of the UHC remains to many Kenyans a pipe dream. This is because of inadequacy of funds to cater for treatment expenses by the population at large. In 2016, a survey of how Kenyans paid for healthcare was done. It was identified that majority of Kenyans paid for health from their savings (Zollmann & Ravishankar, 2016). In so doing, many families were impoverished. Other modalities of payment included insurance companies and a combination of insurance and out-of-pocket payments. Other than the financial strain healthcare has on patients, it does influence the quality of care rendered by the providers.

The case of the health care expenditure should be viewed in the context of the economic empowerment (or lack thereof) of the Kenyans. According to a World Bank report in 2014, 48% of Kenyans lived below the poverty line (Awiti, 2014). As such, only a minority of 22% can afford to secure health insurance (Julie & Nirmala, 2016). On falling ill, the uninsured majority will often have disastrous expenditure. It has been estimated that about 6% of Kenyans will be pushed to poverty due to health care expenditure. The foregoing coupled with increasing body of literature showing that health insurance seems to be a consideration in clinical decision leads to a great need of local data to establish whether health insurance influences clinical decision and if so whether there is any disadvantage to the uninsured.

2) The Problem

Extensive research has been carried out in western countries evaluating the effects of payment modalities on health care. The overwhelming evidence suggests that out of pocket payments are associated with adverse outcomes while funding through health insurance seems to confer benefit. The benefit alluded to is both in terms of health outcomes and financial protection.

In Kenya and indeed the whole continent at large, there is paucity of data of how different modalities of payment affect the payers. The few studies done show no effect of health insurance on quality which contrasts data from western countries. Borrowing from the literature from other countries, it follows that possessing health insurance is likely to be associated with a favourable outcome. This study looks at this concept from a Kenyan perspective. It debunks how the different modalities of payment are likely impact the patients from the clinicians' point of view.

3) Literature Review

Globally, health care expenses are settled with either of the following mechanisms.

1. Out of pocket payments
2. Health insurance payments
3. Co-payment (Health insurance and out of pocket payments)

Health insurance is universally known to offer financial protection and especially so in populations which are poor (Nguyen, Rajkotia, & Wang, 2016; Pekerti, Vuong, Ho, & Vuong, 2017). Paradoxically, since health insurance involves payment of premiums, most poor people will be unable to afford the service and hence are prone to financial distress when they fall ill (Kotoh & Van der Geest, 2016). In other reviews, lack of health insurance has been linked to poor health outcomes over and above causing disastrous expenditure (Bittoni et al., 2015). It has long been established that possession of health insurance confers financial protection (Okoroh et al., 2018). This is true even in the African setting. Various countries in Africa have clearly illustrated that having health insurance was

positively associated with better utilization of health services yet cushioning the patients from catastrophic expenditure (Escobar et al., 2010). Other modalities of payment have their own pros and cons. Out of pocket payers for example are likely to be denied services that are useful just based on their payment modality (Wardle, Sibbritt, & Adams, 2018). Emergency services have been denied to patients who did not have health insurance leading to increased mortality to those uninsured (Joseph et al., 2015).

While health insurance has largely been linked to better outcomes as above discussed, there are instances that it has been misused. In the USA, for example, having insurance might lead to doctors requesting for extra unnecessary tests or other forms of interventions (James & Poulsen, 2016; Moser & Applegate, 2012). This leads to increased cost of healthcare. Locally, Kenyan insurance companies have cried foul over the same issue. It was felt by the insurance companies that doctors were overcharging clients who had insurance covers which has plunged the companies in question to losses, some closing shop (Kubania, 2018).

4) Methodology

This was an explorative qualitative study which utilized an online questionnaire. It was conducted anonymously to Kenyan doctors registered with the Kenya Medical Association (KMA). All members in the KMA database between August 2018 and October 2018 were invited to take part in the survey. Kenya Medical Association is a professional society that deals with social and welfare issues as well as capacity building for the doctors.

Purposive convenient sampling was used since only doctors registered with KMA were targeted in the study. The association was chosen due to its ability to reach out to members via email. Emails were preferred in this study since that was the only way to be sure the target recipients responded once. All doctors on the mailing list were included to increase statistical power. All those who responded, and were eligible, were included in the final analysis amounting to a convenient sample. A response rate of about 20%-30% was expected as has been the with previous online surveys among doctors in low income setting (Wright, 2006).

Data obtained via the questionnaire included demographics of the respondents and the type of practice they were involved in. Respondents were then asked the kind of clientele they served in terms of insurance status. They were then requested to narrate how possession of health insurance or lack thereof affected their clinical decisions on a day to day basis. Further, they were to describe a clinical scenario illustrating how health insurance affected their clinical decisions. Data obtained from the responses was then transferred to an MS-excel spread sheet. The researcher went through all responses colour coding phrases which were repeated by respondents. These were eventually grouped to codes and subsequently into themes. A total of 10 codes were developed which then fit into four themes. Generated themes were reviewed by two competent researchers who largely agreed with the developed themes. Further, code and theme generation were done by NVIVO software to confirm accuracy and reliability of those developed manually. The two sets of themes were comparable. Ethical approval was obtained from the Kabarak research and ethics committee as well as the National Commission for Science, Technology and Research.

5) Results and Discussion

Respondents gave their experiences where insurance had influenced their clinical decisions. Codes developed from the prose were; "inability to pay", "harmful to the patient", "changed the prescription", "referred to a public hospital", "admitted to allowing insurance to pay" among others. The word frequency and word count were as populated from NVIVO was as below.

Table 1: word frequency

Word	Count	Percentage (%)	Similar Words
Patient	123	6.25	patient, patients
Insurance	106	4.23	check, cover, covered, covering, covers, ensure, ensured, insurance, insurances, insured, insurer, see
Required	58	2.02	ask, asked, necessary, necessity, need, needed, needing, needs, require, required, requires, requiring, take, taking, wanted
Treatment	37	1.88	discussing, intervention, interventions, treatment, treatments
Cost	33	1.68	cost, costly, costs
Pay	39	1.64	give, paid, pay, paying, pays, yield
Tests	32	1.47	exam, run, test, testing, tests, try, trying
Afford	36	1.45	afford, affordability, affordable, give, open, yield
Services	35	1.36	availability, available, help, service, services
Medication	26	1.32	medical, medication, medications, medicine, medicines
Cover	50	1.26	back, cover, covered, covering, covers, extend, treat, treated, treating

The dominant themes emerging from the responses were categorised as follows
1. Suboptimal care to the uninsured
2. Preferential treatment for insured
3. Exploitation
4. Poverty and desperation

5.1 Sub-optimal care to the uninsured

Many instances involved the uninsured failing to obtain intervention(s) due to their inability to pay. Some included emergency situations which ideally would need instant attention. A respondent intimated how a "*fracture that required surgery was managed by casting/traction.*" In another instance, a clinician reported that "*patients get MVA (manual vacuum aspiration) under anesthesia in private hospitals with insurance cover. While in public facilities or when there is no insurance anesthesia is not provided.*" In such cases, it was clear that the patient was disadvantaged due to lack of insurance.

While some cases involved withholding or offering sub-standard intervention, another group of respondents reported that those who lacked insurance would be referred to the nearest public hospital. In a case where a patient required ICU (intensive care unit) admission, a respondent decided to "*transfer the patient to a public facility as they could not raise the deposit.*" One reported a case of a patient with an ectopic pregnancy who was sent to a public hospital since "*her insurance could not pay at a private facility.*"

In other responses, clinicians indicated how they substituted medication to cheaper ones or do an alternative (cheaper) investigation at the instruction of the insurances. Following are a few excerpts from respondents demonstrating the same.

> "*Patient needed drugs that are not covered by their insurance especially under the NHIF cover including the cheapest alternative, am forced to give analgesics and give the patient a prescription hoping that they will buy it out-of-pocket, which they likely won't.*"
>
> "*I've had to discharge (on patients request) because of inability to pay out of pocket as the patient had no insurance*"
>
> "*I had to allow patient home when they needed an admission because they had no NHIF and no capacity to pay otherwise*"
>
> "*When a patient has no medical insurance, fewer lab tests are requested and fewer (and cheaper) medicines are prescribed"*
>
> "*Insurance outpatient cover was limited in the scope of investigations. The client had to be admitted in order to access the services. This, of course, wasted man hours for both the client and hospital staff. I wish insurances would cover more costs of preventive/health promotion health interventions"*

One case stood out where a certain patient presented with a miscarriage. The respondent and the patient agreed to medically manage the condition. When authorization was sought from the insurance, the insurer declined as it "*did not recognize this as a standard treatment and hence they would not pay. the patient had to settle for surgical management instead, which was costlier (sic).*"

All the above situations point at the magnitude of influence health insurance has on clinical decisions. It was clear that in many occasions the patient would likely be harmed if they lacked health insurance. In cases involving referring an emergency case to a public hospital (which is likely cheaper), there is no certainty that the patient would receive the intervention or even get to the hospital in the first place. This, therefore, could be harmful to the patients. Further, as cited above by one respondent, some insurances would have slim patient services but broad inpatient coverage prompting clinicians to offer unwarranted admissions. This is a waste of resources and exposing the patient to risks of nosocomial infections.

In contrast to unwarranted admissions are the denied/declined admissions. Respondents reported of patients who needed to be admitted and due to lack of insurance or low insurance capitation could not be admitted. Other cases were described where important investigations were forgone since insurance would not pay, or those without insurance could not afford. This, according to respondents, would limit their capacity to make a diagnosis and hence offer appropriate treatment. By and large, those without health insurance were perceived to experience negative predicaments ranging from no care to sub optimal care. It reinforces the concept that health insurance might confer benefit to patients. This is in keeping with other conclusions elsewhere in Africa and beyond.

5.2 Preferential treatment for insured

Respondents described in detail what they considered when making clinical decisions. Some asserted that the clinical status of the patient was paramount and hence offered the best available within their setting. These proposed that they would advise patients on what was best for them and leave the decision of payment/affordability to the patient. For instance, a respondent indicated that they would "*tell the patient/relatives what NEEDS to be done and they organize themselves to try to have it done*."

This sentiment was shared by several other respondents.

> "*If I feel an intervention is important or lifesaving and insurance cannot pay, I inform the patient and let the patient decide if he/she can pay out of pocket*"
>
> "*Severity of disease-supersedes ability to pay if stable and investigation necessary, I consider referral to a government or more affordable hospital*."
>
> "*Clinical decisions are based on the case presentation. You have to offer all the possible and available interventions and inform the clients of what is available at the current set up or elsewhere. Then the decision lies with them because you have offered them possible solutions.*"

Most of the respondents however mentioned affordability and patients' ability to pay for the services as key in their decisions. This group still agreed that a patient's clinical situation was important but could not solely be used as the determinant. One reported that they considered socioeconomic status since patients would "*decline clinical decision if unaffordable or avoid follow up to avoid more cost not covered by insurance*."

In an illustration of the interplay of several factors in decisions, a respondent aptly put it that they are "*mindful to keep costs as low as possible for patients who have no insurance coverage. That means that I only ask for tests that are absolutely necessary for diagnosis/management and prescribe generic rather than original drugs. I, however, will not comprise the best practice for lower costs*." This same theme was shared by most respondents.

> "*I resolved to give the best care and inform the patient. I prescribe and document what the patient needs and give cheaper alternatives. If still u affordable to the patient, I tell them of the importance and hope they will one day do it"*
>
> "*Availability, accessibility and possible clinical outcomes, on a case by case basis"*
>
> "*State of the patient, immediate danger to life, ability to pay"*
>
> "*The disease condition of the patient, what is the bare minimum the patient requires for diagnosis and treatment, the ability to settle the bills*"

According to the responses given, health insurance played a crucial role whenever respondents make decisions. It appears that while respondents are cognizant of patient's clinical status, this alone may not determine what decisions they take. Top on the list of things that the majority indicated would be considered is insurance status and/or their ability of patients to pay for the services. This is understandable since health care in Kenya is largely financed by payments from clients. Some services are free or subsidized at public hospitals, but such hospitals usually have severe and recurrent outages of resources.

It is a possibility that clinicians consider giving the best care available weighed against the financial implication on the patients. As many explained, they consider it futile to pursue standard practice (either in treatment or investigation) which is expensive in patients who will not afford it anyway. In lieu, they offer other alternatives to try to help the patients. While this is in good faith, there are some circumstances where doing so can cause harm. An example is when staging cancer to determine the initiation of chemotherapy. Several respondents agree that correct staging needs expensive forms of imaging like MRI and CT scan. When these are not affordable, some respondents will use clinical judgment or inferior forms of imaging to initiate therapy. This could easily increase error rate in the said clinicians. It appears that the respondents are stuck in a limbo; striving to give the best care to patients but limited by the patients' inability to pay.

5.3 Exploitation

Due to the assurance of payment in the case of insured patients, some respondents averred that they would be inclined to doing several tests or admitting even if such was not warranted in bid to earn more money. Some of these would be directives from the hospital management to help increase the revenues. A respondent described a case where the clinicians were required to do investigations and was to find out later the hospital had a loan to repay and the investigations helped raise the funds.

> "*Branch manager wanted FHG run for all clients with infective conditions, rotaviral and testing for all cases of infant diarrhoea and urinalysis before prescribing UTI meds, apparently to meet a 25 million shillings a month quota for the health centre"*

This agrees with the trend elsewhere where insured patients were found to be prone to having many investigations (Shen et al., 2014). It also seems to validate a concern that insurance companies in Kenya raised accusing doctors and hospital exploiting the insured clients for financial gain (Kubania, 2018).

5.4 Poverty and Desperation

A worrying theme that was identified was poverty. In several cases, respondents explained how poor patients were less likely to have health insurance. This inherently disadvantaged them since most of the patients would not get the service they needed. Some would either be turned away or referred to a public hospital. A gloom picture was painted for patients with cancer. Such patients routinely require intensive and often expensive investigations. These would not be possible for those without insurance and as such, it would be hard to diagnose or even determine which modality of treatment to offer. This led to late diagnoses and at worst, mortalities.

A certain clinician wrote about a "*Stage 4 Cervical cancer patient who needed immediate transfusion and hysterectomy followed by chemo and radio but did not have NHIF to be able to access the services*". One is left to wonder the outcome of such patients. While this is certainly worrying, it is congruent with other places which have shown obvious disadvantage to patients who lacked insurance including cancer patients (Black, Espín-Sánchez, French, & Litvak, 2017). In other trauma cases, lack of insurance was positively associated with failure-to-rescue. This brings the observation that the poor who are without insurance then suffer worse outcomes and consequences in terms of disease burden. The patients then are desperate and have little to do than wait for the natural course of the disease or at best, delay treatment as they look for funds.

6) Recommendations

A recommendation is made to the government to expedite the implementation of universal health care. This will relieve the burden of payments from patients and therefore allowing clinicians to offer all necessary services without concerns of impoverishing patients or assurance of payment for services rendered. Clinicians attending to patients without insurance are advised to consider cost and offer standard of care. In events where patients are unable to afford care, appropriate redress like referral or waivers can be employed. To those who are insured, rational use of interventions is advised and desist from overcharging or doing excessive tests just because there is assurance of payment. Insurance providers can consider using capitation as the model of reimbursement as this has been shown to reduce misuse by the providers.

7) Conclusion

Possession of health insurance is likely to confer benefit to patients, conversely, lack of health insurance is perceived by doctors to likely lead to sub optimal medical care. In some cases, having health insurance can be abused by clinicians leading to over-investigation which increases their revenues. Most clinicians however describe a situation in which they are willing to do the right thing, offer the appropriate intervention but the economic situation of the patient becomes a limiting factor. An ethical dilemma in which the doctors are unable to solve. This calls for a concerted effort by all stake holders to improve access of healthcare to all in Kenya.

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