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FACTORS AFFECTING ACCESS TO HEALTH INSURANCE PRODUCTS PROVIDED BY MICROFINANCE INSTITUTIONS IN WESTERN PROVINCE OF KENYA

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Abstract

Purpose: The purpose of this study was to determine the factors that affect access to health insurance products offered by Microfinance institutions in Western Kenya

Methodology: The research focused on all the registered MFIs operating in Western province of Kenya and their clients. A sample of two hundred respondents both insured and uninsured was selected. Interviews and review of administrative records were used to gather relevant information for the study. The research employed a descriptive and non-experimental design in which both qualitative and qualitative methods were used to analyse data. The data gathered was analysed using MS-excel and summarized using descriptive statistics in form of tables, percentage and graphs. Textual data was analysed qualitatively using frequency tables.

Results: The study found that most members of the MFIs were earning less than a dollar a day. The study also found sixty eight percent of the respondents did not have healthcare insurance for themselves or members of their households. The respondents indicated that the main impediment to their uptake of healthcare insurance products was lack of funds to pay the premiums. The respondents also indicated that there was failure by the MFIs to carry out awareness programmes for the healthcare products. The study also found out that women are the majority clients of the MFIs at 78%.

Unique contribution to theory, practice and policy: The study recommended that MFIs should strive to bring in the men into their net. The study also recommends that the MFIs need to liaise with strategic partners in the grassroots in the regions they operate in like the churches and schools to raise awareness of the healthcare insurance products. The study further recommended that future research be conducted to investigate the specific effect of each of the factors identified in this study. A future study could be for example conducted on the effects of education or culture on the adoption of healthcare insurance products offered by the MFIs.

Keywords: *access, health insurance products, microfinance institutions*

1.0 BACKGROUND OF THE STUDY

One of the objectives of the Kenyan Vision 2030 is to promote and improve the health status of all Kenyans by making health services more effective, accessible, and affordable (Republic of Kenya, 2007). The vision is built on the achievement of Economic Recovery Strategy for Wealth and Employment Creation (ERS), (Republic of Kenya, 2003), and the National Health Sector Strategic Plan II (NHSSP II) (Republic of Kenya, 2005). The NHSSP II was formulated with an aim of reversing the downward trends in the health indicators during the 1990s

Concerted preventive and promotive health measures further reduce mortality and morbidity within the productive sectors of the country's population especially among women and youth. Women occupy a special place in efforts to improve health because they participate in many activities that affect the health and wellbeing of their families. They offer an estimated 60 percent to 80 percent of all agricultural labour in Africa, thus placing them in an important position to contribute to food security and nutrition (King & Wang, 1993). Investors shun environments in which the labour force suffers a heavy disease burden (King & Wang, 1993). The effects of poor health go far beyond physical pain and suffering. Learning is compromised, returns to human capital diminish, and environments for entrepreneurial and productive activities are constrained. According to the World Bank (2003), no country has attained a high level of economic development with a population crippled by a high infant and maternal mortality, pervasive illness of its workforce and low life expectancy. Worldwide, empirical evidence shows that poor health imposes immense economic costs on individuals, households and society at large (UNDP, 2003).

The Poverty Reduction Strategy Paper (Republic of Kenya, 2001), recognized the role of the MFIs in both employment and wealth creation, through the lending to the Micro Small Enterprises (MSEs) who play an important role in poverty reduction strategy. The provision of financial services to the low –income households and MSEs, provide an enormous potential to support the economic activities of the poor and thus contribute to poverty alleviation. More broadly, it refers to a movement that envisages "a world in which as many poor and near-poor households as possible have permanent access to an appropriate range of high quality financial services, including not just credit but also savings, insurance, and fund transfers"(Robert et al, 2004: 28).

An efficient healthcare system is critical in breaking the vicious cycle of poverty and poor health. Moreover, it is critical in meeting the Millennium Development Goal (MDG) of marked improvements in the health of the poor by the year 2015. For many developing countries, the goal of providing affordable healthcare to all has been an arduous task. In an attempt to improve access to affordable healthcare, a number of sub-Saharan African countries adopted several models of healthcare financing, most of which have been wholly unsuccessful at reaching the poor. These healthcare financing models range from a "free health care for all" model to a fee collection at the point of service popularly referred to as user fees or cash-and-carry model (Adjeil, 2007)

Throughout the four decades after independence (1963-2003), the government of Kenya has used several methods of financing health services. Until 1965, co-payments of Kshs. 5.00 per user were in force in all public health facilities. This flat rate fee was paid for every visit made to a health facility, regardless of patient's health condition. Between 1965 and 1989, the government

used revenue from general taxation to finance health services. This was in line with Government policy of free medical care, as stated in Sessional Paper No. 10 of 1965 (Republic of Kenya, 1965).

During the decade of 1980s, free health care in Kenya become unsustainable due to poor economic performance and increased demand for health care services, a situation which lead to reduced efficiency and quality of services in Government health facilities. Since the Government could not single-handedly sustain the provision of free medical services, development of alternative financing mechanisms become inevitable. Subsequently, the Government developed Sessional paper No. 1 of 1986 on Economic Management for Renewed Growth The paper outlined Government priorities relating to financing of health care services as strengthening of NHIF and introduction of cost sharing in public health facilities. The cost sharing policy was introduced in the public health sector user fees in December 1989 as part of government initiatives to mobilize additional resources in the health sector.

While the cost sharing program introduced in 1989 had some positive contributions to the country's health care system by keeping many public hospitals running at a time when the resource flows from the government were by far inadequate, it has not met the intended impact of reducing the short falls in health care financing. The health care financing reforms of the late 1980s and early 1990s brought about reduced attendance in Government health facilities by between 40-50 percent mainly because the costs of care were not affordable (Mwabu et al, 2002). The current system of cost sharing in the health sector is based on the assumption that the majority of the people can afford to pay medical care at the point and time of treatment. There are two major problems with this assumption. First, it is not realistic in a situation where about half of the population lives below the poverty line. Second, it discourages people, who can pay for treatment before the illness occurs from making such payment.

The leading causes of outpatient morbidity in western province between, 2005-2007 we malaria 44 percent, disease of respiratory system 17 percent, disease of skin (including ulcers) 6 percent diarrheal diseases 5 percent, pneumonia 4 percent, accidents 3 percent and others 21 percent. Western Province has the largest number of births at home i.e. 70 percent compared to the rest of the Provinces and it has one of the highest infant and maternal mortality rates in the country (Republic of Kenya, 2005)

Microfinance Institutions realized fighting poverty needs a multi dimension strategy and not just offering financial services to the poor and that is why they came up with the health insurance products for the poor. MFIs have organized and managed health care financing schemes which provide access to preventive and curative health services as well as financing in form of health saving plans and emergency health loans for the poor. This was to provide the poor and the financial vulnerable people with means to cope with financial shocks associated with sudden illnesses. Integrating healthcare financing into a well-established microfinance organization is a unique way to bring healthcare financing to many communities and to mitigate the financial risks associated with poor health. MFIs are the perfect intermediaries in this effort as they can leverage the outreach and the rapport that they have established with their clients and the community to reach a greater number of people, thereby making these financing mechanisms available to a larger population. It is in this respect that a study on factors affecting access to the health insurance product is vital.

1.1 Problem Statement

A healthy and productive workforce guarantees optimal output, which in turn helps to generate the much needed revenue base for a healthy economy. A productive and healthy workforce is therefore an essential ingredient for economic growth and prosperity (Dean, 2006). If better health improves the productive potential of individuals, good health should accompany higher levels of national income in the long run. The poor tend to suffer higher rates of mortality and morbidity than do the better-off. They often use health services less, despite having higher levels of need. And, notwithstanding their lower levels of utilization, the poor often spend more on health care as a share of income than the better-off (Republic of Kenya, 2005). Indeed; some non-poor households may be made poor precisely because of health shocks that necessitate out-of-pocket spending on health.

Although the government has provided free health services in public health centres and dispensaries, the majority of Kenyans still do not have access to affordable and quality health care. Government official statistics suggest that about 49 percent of the population residing in rural areas live below the poverty line (Republic of Kenya, 2006), with no access to health services. However, the government efforts have not been successful, thereby making policy makers look for a better solution. In order to address the challenge of access to health care, the government has warmed up to microfinance institutions which finance health care through microfinance products. This comes after a realization that the concept has worked in Bangladesh and India.

Despite the efforts made by Microfinance to avail health insurance products to enhance access to health care services at affordable prices, poor people are still unable to access health care services at both private and public health facilities. Hence there is need to explore the factors that limit people from accessing these health insurance products offered by the MFIs. The purpose of the study was to analyse the factors that affect access to health insurance products provided under the Microfinance health insurance schemes in Western Kenya.

1.2 Research Objectives

The general objective of the study was to determine the factors that affect access to health insurance products offered by Microfinance institutions in Western Kenya

The specific objectives were to:

i. To establish personal characteristics of the beneficiaries that affect access to health insurance products.
ii. To determine institutional factors that affect access to health insurance products
iii. To establish effects of government and global health policies on access to health insurance products provided by Microfinance Institutions.

2.0 LITERATURE REVIEW

2.1 Empirical Review

The personal factors that affect access to health insurance products include but not limited to age, income, social status, health status, awareness, education and culture. Families with children less than five (5) years tend to use health facilities more; they are more vulnerable to diseases. Most of them are forced to take insurance or ensure there is ready money to take care of hospital bills

for these children (Republic of Kenya, 2005). The level of income goes a long way to determine the kind of service individuals want to consume. The higher the income of an individual, the high the probability of the individual being able to set aside some money for emergencies, including health issues. According to the 2002 public expenditure review (Republic of Kenya, 2002) the poor households do not seek health care services as much as the well do in the society and if they do ,it must be in those extreme cases although still ,they are not able to foot the medical bill.

Better education allows an individual to be more effective in converting health care and other health-enhancing goods into health. A study by Grossman and Kaestner, (1997) on the effects of schooling on health found education to be the most important correlate of good health. Many cultural, religious, or social factors may impede the use of health care services. In communities where women are not expected to mix freely, particularly with men, utilization of health services from static facilities may be impeded. In some communities in Bangladesh, the restrictions of purdah may prevent mothers from accessing medical treatment for themselves or their children (Rashid *et al.* 2001). The presence of male practitioners for obstetric and gynecological care has been shown to be an important reason for low use of these services by Asian women in Western societies (Whiteford & Szelag, 2000). It is suggested that in the United Kingdom, the clustering of patients of the same ethnic origin in practices staffed by people with the same language and cultural background is one reason for the high registration and consultation rates with general practitioners in many predominantly South Asian communities (Goddard & Smith, 1998).

The institutional factors considered include management, funds availability, coverage and distance of micro finance institutions and the health service facilities. 2008 Microfinance funder Survey showed that most of the source of funds for microfinance institutions is by the donors and investors (CGAP, 2008). Out of total global committed amount of 11,687M, United States dollar 1,642M was allocated to the Sub-Sahara Africa that is 14 percent of the total funds. 79 percent of the above funds were from donors and the remaining 21 percent was from investors (CGAP, 2008). Depending on the source, levels /purpose, and instrument of the funds, the microfinance institutional should follow the set regulation or else the funds can be recalled back or there will be no future grantee for more funds for expansion and growth. The management of MFIs must strive to run the organization and use the funds as per the donor's regulations.

Leadership within the MFI must understand the context of the country to formulate a strategy, structure, and system that will be effective. Senior executives in the MFI must be knowledgeable, support the organization, and effectively communicate the mission, vision, and strategy to the other members of the organization. An excellent senior leadership team and board of directors are key elements of MFI success. The ability to effectively lead the organization could be measured through client and employee ratings and years of microfinance experience.

The most successful operation of MFIs is through strengthened linkages with their formal sector counterparts. The managers of MFIs must be able to come up with product mix that is sustainable and beneficial to the members/clients of that MFI. Although clients may benefit from non-financial services, they may not be willing (or able) to pay enough to cover the costs of service provision. Therefore, offering such products and services adds to MFIs' costs but may not lead to a corresponding revenue increase. It's the responsibility of the management to come up with strategies that will give them competitive advantage over the others at a reasonable cost. The management of the microfinance institutions must steer their organization to become

financially viable, self-sustaining, and integral to the communities in which they operate, they have the potential to attract more resources and expand services to clients.

Even if the potential benefit of health insurance is seen, there is no utility in insurance if the poor in the rural have no geographical access to health facilities that are accredited by a health insurance. Similarly, the non-availability of quality health care services (including lack of drugs and other quality deficits) negatively affects demand for health insurance (Carrin, 2003). Thus if the poor in the rural perceive quality of health care as a problem, health insurance products provided by microfinance will be less attractive to them.

Distance to the health facility affects access to health insurance products provided by the MFIs even if the insurance cost is reasonable, people will be discouraged as they need to spend more money and time on getting health care if their homes are far away from the health facility. Availability of transport affects the degree to which distance is a barrier. The restrictions imposed on women by Purdah may themselves mean that the impact of travel time on utilization is much more important for women than for men. One study in India, for example, found that travel and time costs had a much greater negative impact on female access to services than the direct user charges (Vissandjee *et al.*, 1997).

The first global summit on micro credit was held in February 1997 in Washington DC and since then twelve others have been held in different countries as a follow up. In that summit of 1997, United Nations General Assembly and its resolution number 52.194 officially declared the year 2005 the International year of Micro Credit (United Nation, 1998). In this resolution the General Assembly resolved that between 1997 and 2005 member states should commit themselves to launch a global movement which would reach 100 million of the world's poorest families with the micro facilities for self – employment.

The General Assembly recognized and appreciated the role of Micro Finance Institutions in the growth and transmission of micro enterprises as a global phenomenon of poverty alleviation, poverty eradication and wealth creation among the world's poorest. The plan of action agreed on was for the member states to set up National proactive micro credit forums in their respective countries and ensure easy access to micro credit before the year 2005 (United Nation, 1998). Since then, 41.6 million poorest clients have gained access to financial services (Daley, 2003).

In November 2004 the Government of Kenya initiated compliance to this resolution by officially launching 2005 as the year of micro credit at a colorful conference exhibition and ceremony at Kenyatta International Conference Centre Nairobi. However access to easy credit on reasonable terms by the majority of the most economically disadvantaged of Kenya population has yet to be realized (Republic of Kenya, 2004).

The government of Kenya passed the Finance and Microfinance Bill in January 2007 (Republic of Kenya, 2007).The bill regulates all Micro Finance institutions operating within its borders. This was drafted in 2000 and it requires all Micro Finance Institutions to be opened to mandatory audits by the Central Bank of Kenya. The aim of the bill was to curtail the entry of bogus MFIs into the market and protect the nearly 60 percent of the Kenyan population who are out of the scope of formal banking. Before the enactment of this bill, the MFIs operating in Kenya (over 200) were unregulated unless they optionally entered the Association for Microfinance Institutions (AMFI, 2007). With this regulation, the micro-finance sector is expected to lead to quality growth, broaden the funding base for MFIs eligible to mobilize and administer deposits,

credit facilities, other financial services, and initiate the process of integrating these institutions into formal financial system (Republic of Kenya 2007).

Health and financing MFIs are going beyond Credit with Education to deliver health financing mechanisms, such as dedicated health savings accounts and emergency health loans to their clients. Some MFIs have leveraged their local influence and business acumen to create reliable linkages with providers, negotiate rates, and advocate for better quality and accessibility of health care. For accessibility to health products, some MFIs use a network of health workers to sell essential but scarce health products door-to-door to the poor in the rural areas. Some MFIs offer loans to their members to enrol in micro insurance programs and they spread the annual premium payments over a period of time (Dunford, 2008).

3.0 RESEARCH METHODOLOGY

A descriptive design was applied in which both quantitative and qualitative data was collected to assess the factors affecting access to health care insurance products provided by microfinance institutions in western province of Kenya. Information was gathered both prospectively and retrospectively covering a period of one month. All the eight (8) registered Micro Finance Institutions and their clients formed the population of the study. The sampling was done in three stages; first stage surveyed all the MFIs operating in western province and randomly selected those to study. In the second stage, members from the above sample of MFIs were randomly selected as census was not possible. The third stage assigned the members per MFIs and these were done proportionately to their member's base. After that the members were chosen by a simple random method. These microfinance institutions have a population 10,000 members out of which 6,500 were selected from the 5 MFI above. Out of the 6,500 members above only (147) of the members were interviewed. Data was gathered from the study sites using the interview guides and questionnaire. Thereafter, the information was coded and entered into an excel spread sheet and analyzed using MS-excel. The MS-Excel was used to generate summarized descriptive statistics. Data gathered from key informant interviews (managers of MFIs) was analyzed qualitatively based on the themes. A thematic and content analysis followed along the main themes (i.e. research questions and/or discussion topics) of the study focusing on issues and patterns that pervade the data.

4.0 RESULTS AND DISCUSSIONS

4.1 Response Rate

Out of the 147 questionnaires administered, 108 were properly filled and returned representing a 73.5%response rate. Five managers were interviewed to complement the responses gathered by the questionnaires.

4.2 Personal characteristics of the clients

The characteristics of the clients' respondents are discussed in the following section and their relation to access of healthcare insurance products illustrated. The study findings showed that women are the majority of the clients of MFIs in Western Province at 78%. This stresses the fact that MFIs have fostered the empowerment of women in the rural areas. The study argues that women are the ones concerned most with the health matters of their families and the general

wellbeing of their households and thus their overwhelming involvement in microfinance activities.

4.2.1 Marital status

The largest portion, (65%), of the clients was married. Ten percent (10%) were single and never married, 16% were widowed, 12% were divorced and 1% was separated. The findings imply that married respondents were more likely to be involved in microfinance institutions due to the benefit it affords their families.

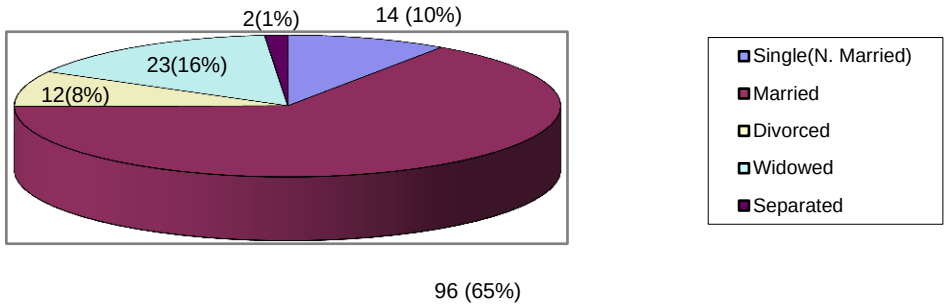

Figure 1: Respondent's marital status

4.2.2 Highest level of education

From the figure, it is clear that most of the respondents had attained their highest level of education as being primary certification with 59%, and secondary schooling having 29%. 13% of the respondents indicated that they had no education past the nursery school, while only a mere 3% said they had university level of education. This point to the fact that most of the clients of MFIs were rural folks who have little or only basic education. This finding implies that the low level of education may have led to the low access of health insurance products.

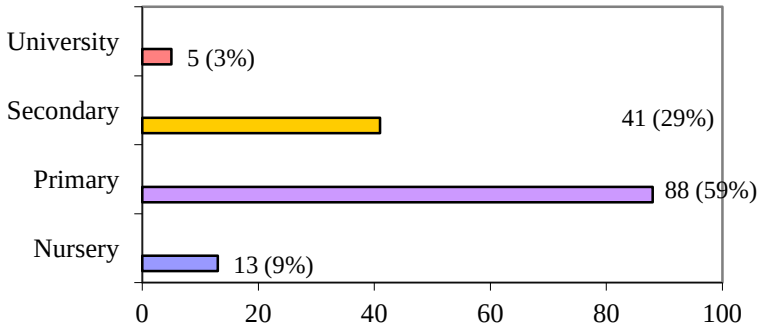

Figure 2: Highest Education Level

4.2.3 Religion

The study sought to establish the religious background of the respondents. The responses are shown in the table below. From the table, it emerges that most of the clients were Christian either catholic (32%) or protestant (50%). Traditionalists were 13% while Muslims were 5%. This implies that most of the respondents are exposed to religious teachings as the churches stress on the need for better and healthy individuals, hence the sensitization of the microfinance health products. The churches are good socialization and meeting places where awareness for microfinance products were likely to be discussed. However, the finding implies that religious inclination (being dominantly Christian) in this study have not contributed to a higher access of health insurance as expected.

Table 1: Respondent's Religion

Religion	Frequency	Percentage (%)
Christian (Catholic)	47	32
Christian (Protestant)	74	50
Muslim	7	5
Traditionalist	19	13
Total	147	100

4.2.4 Employment Status

The respondents were asked about their employment status. The responses are illustrated and discussed below.

Table 2: Employment status

Income Generating Activity	**Frequency**	**Percentage (%)**
Employed (Formal sector)	7	5
Self-Employed (Informal sector)	68	46
Employed (Informal Sector)	34	23
Unemployed	17	12
Others	21	14
Total	147	100

Most of the respondents indicated that they were self-employed, 46%, while 23% were employed in the informal sector. 12% were unemployed while 5% were employed in the formal sector. 14% indicated that they were either farmers or casual laborers in the farms. The results show that over 90% of the respondents in the study were thus earning their income from the informal sector and the Small and Medium Enterprises in the region. The finding implies that the observed employment status could have led to the low access of health insurance products.

4.2.5 Level of Income

On the issue of average monthly income the respondents indicated that most of them earned around KShs. 2,500 and supplemented their earnings from their subsistence farming. This

finding may explain the low level of access to health insurance products as a low level of income is associated with a perception of lack of affordability of health insurance products.

4.2.6 Family Size

The study sought to know the size of the families of the respondents.

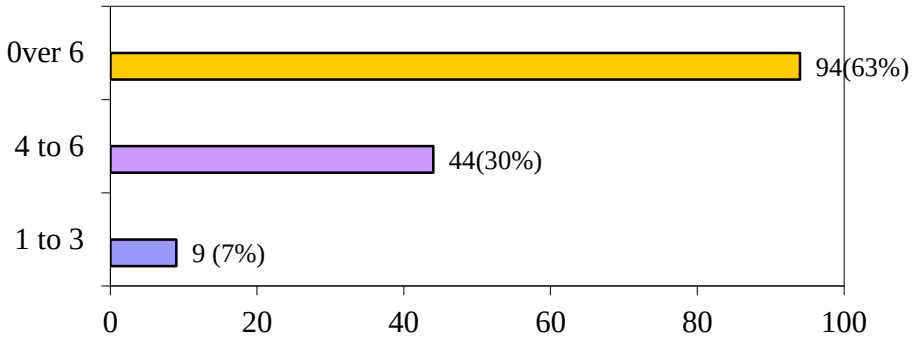

Figure 3: Family Size

The results show that the majority of the respondents (63%) live in households with over six persons. 30% of the respondents indicated that they were residing in household with between four to six members while the rest, 7%, indicated that they lived in households with one to three members. This is in line with the fact most households in Western Province are large.

4.2.7 Access and awareness to health insurance products

On the question of how many of the household members had health insurance cover, the majority of the respondents,68%, indicated that none of the members of the household had health insurance cover. However, out of the respondents who indicated that some of their household members had health insurance cover, it was noted that the majority came from small households. This finding may imply that there is a higher likelihood of accessing health insurance cover for smaller households than larger households. Consequently, the existence of large households may have contributed negatively to the access of health insurance products in Kenya. On the question of what products the MFI was offering, the majority, 40%, of the respondents indicated that only loans were offered. 50% indicated that only savings accounts were offered, while 10% indicated Health insurance only. In addition, 90%, indicated that both loan and saving products were offered. The findings may either be an indication of a lack of awareness or the lack of diversity in products offered by MFIs.

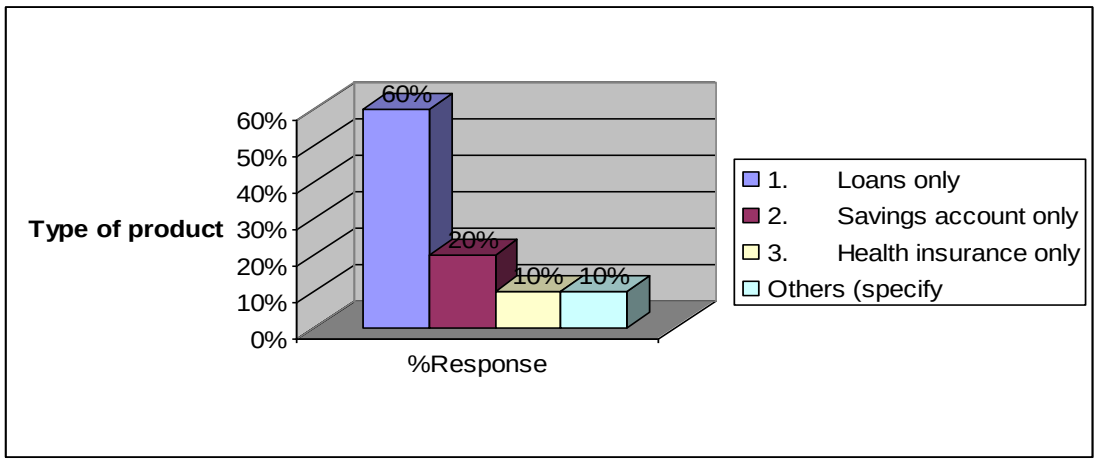

Figure 4: Type of Product

The respondents were asked to indicate the extent to which they were aware of the health insurance products provided. The results are illustrated in the figure below.

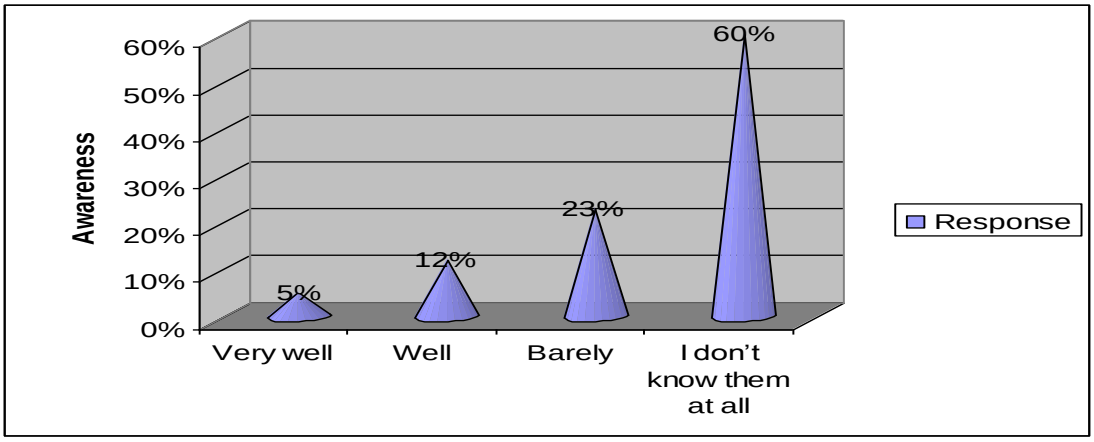

Figure 5: Awareness of Healthcare Insurance Products

The result illustrated above paint a grim picture of the awareness of healthcare insurance products in the region. 60% of the respondents indicated they did not the various health insurance products offered by MFIs. 23% percent of the respondents indicated that they barely knew anything about healthcare insurance products. Only 12% and 5% of the respondents indicated that they were well aware or very well aware of the health insurance products respectively. The finding implies that lack of awareness could have contributed to the low access of health care in the region. The respondents were asked whether they or members of their household had been sick in the four months preceding this study. The responses are illustrated below.

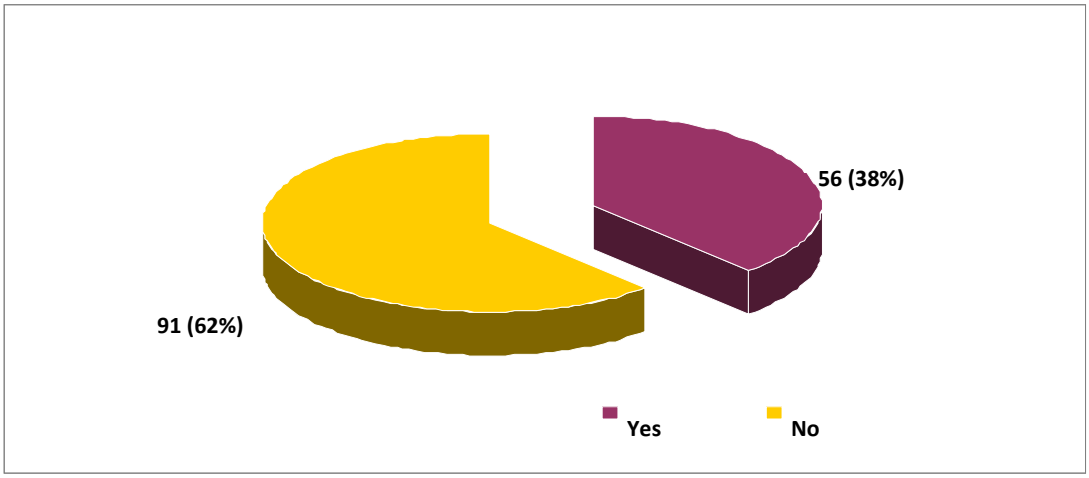

Figure 6: Incidence of Sickness

The results show that, 62%, of the respondents indicated that them or members of their households had been ill in the four weeks preceding the study.

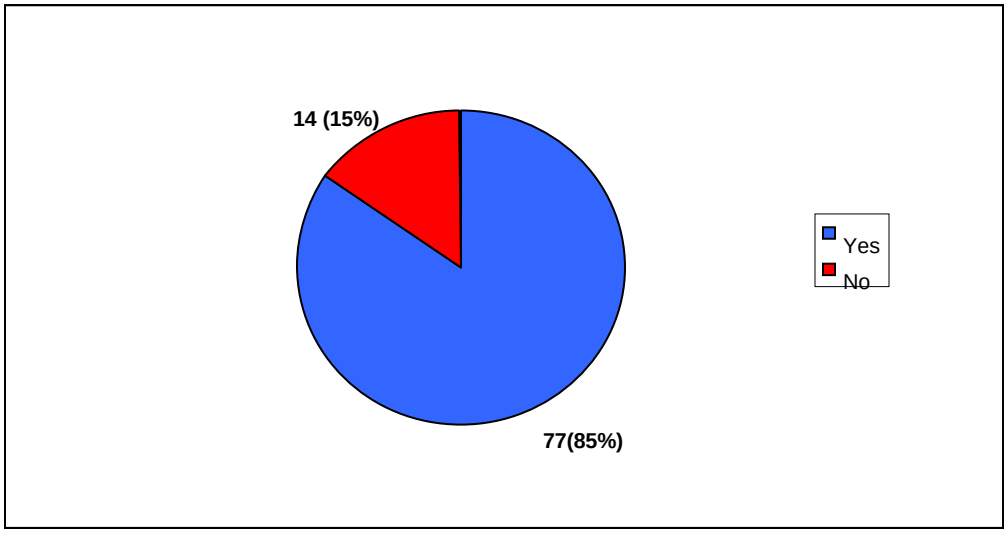

Figure 7: Frequency of Consulting a Health Practitioner

The rest 38% of the respondents indicated that their households did not have illnesses or sicknesses in the four weeks preceding this study. Of those who indicated that they had been sick, they were asked whether they sought help or consulted a health provider. 85% of the respondents indicated that they did not consult a health care provider while the rest, 15%, indicated the contrary saying they did not seek help from a health consultant. Of those who indicated that they sought help from a medical consultant, they were asked what sort of a consultant they visited or sought medical assistance from. Most of the respondents attended government sponsored health facilities as well as mission hospitals and dispensaries while a handful of the respondents sought help from traditional healers. Those who did not seek help from any health provider were asked why they did not do so. Most of them cited lack of money. Others indicated that they did not seek medical help as they considered the ailment not serious enough to warrant seeking help from a healthcare provider.

4.3 Management Responses

4.3.1 Duration of Existence and Operation by the MFIs

The duration of service by the MFIs in the province varied from 5-12 years as shown in the table below.

Table 3: Duration of operation

MFI	Duration
Faulu Kenya	7 years
Jamii Bora	5 years
Jitegemee credit	12 years
K-Rep Development Agency	8 years
Kenya Women Finance Trust	6 years

Faulu Kenya has been in operation in the region for 7 years; Jamii Bora has operated for 5 years, Jitegemee credit for 12 years, K-Rep Development Agency for 8 years and Kenya Women Finance Trust for 6 years. Thus the institutions have been active in the region for a reasonable period of time during which their services and products have become well known. However, compared to the duration of existence of banks in the same region, (which have been in existence for over 30 years), then this finding may imply that the short duration of existence of MFIs have been responsible for the slow access of health insurance products. According to managerial records, the majority of the clients for the five MFIs were women, 82%, while the rest were men (18%).This finding is consistent with the response by the clients. The findings may indicate that lack of inclusion of men in the MFIs clientele may have been responsible for the low access to health insurance.

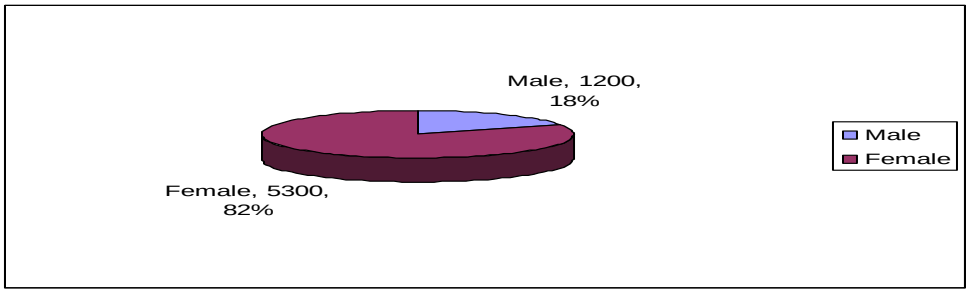

Figure 8: Sex

On the question of how many male and female clients had taken up the various MFI products, the five managers responded as follows: The highest proportion of total MFI savings, 86%, was mobilized from women. Men only contributed only 14% of the total MFI savings. This finding is in line with the findings on sex as a higher proportion of women are expected to contribute a higher proportion of savings.

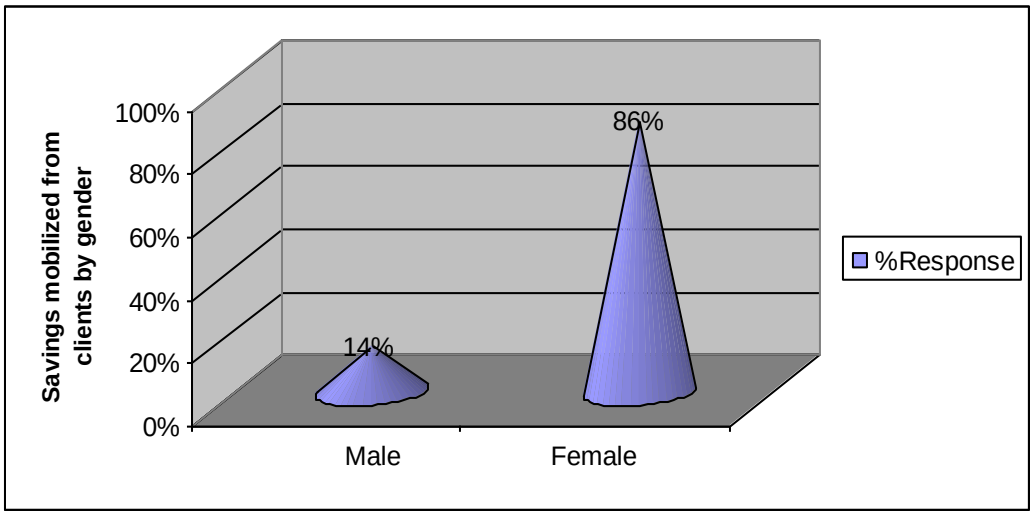

Figure 9: Savings Mobilization by Gender

4.3.2 Financial and Other Services Provided to Clients by Gender

Findings in this study indicate that the majority of the clients who had accessed loan/credit products, saving products and health insurance products were women. This was supported by 83%, 82% and 74% respectively. However, it is worthwhile to note that compared to other products, health insurance was the least accessed by both male and female clientele.

Table 4: Financial and Other Services Provided to Clients by Gender

Financial and other services provided to clients by gender (2009)	Male	% Male response	Female	% Female response	Total
Loans /Credit	1050	17%	5240	83%	6290
Savings Account	1200	18%	5300	82%	6500
Health Insurance	200	26%	560	74%	760
Other, Specify	0	0%	0	0%	0

According to the study, of the 6500 clients, the majority who were women at 80% and 70% had accessed loans amounting to 0-5000 and amounting 5001-10000 respectively. However, it was also observed that men formed the majority at 70% and 80% when access to loans amounting to 10001-20000 and above 20000 was considered respectively. The findings are consistent with conventional findings that women are more risk averse than men and hence borrow more prudently than their counterparts who are men.

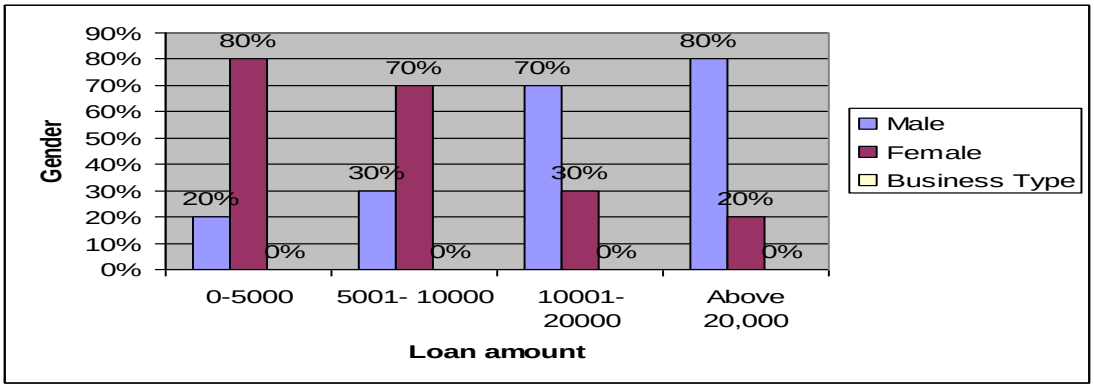

Figure 10: Loan amounts by Gender

The managers were asked whether the MFIs had tailor made products for the region. Majority of the managers, 81%, observed that the MFIs were having in place tailor made products for their clients. The most utilized product was seen as taking of small loans. All the managers interviewed indicated that the MFIS had healthcare insurance products which included small loans given to procure medical help and insurance schemes whereby the members were required to contribute a monthly amount of money (premiums) which could is used by the MFIs to foot medical bills in case of sickness.

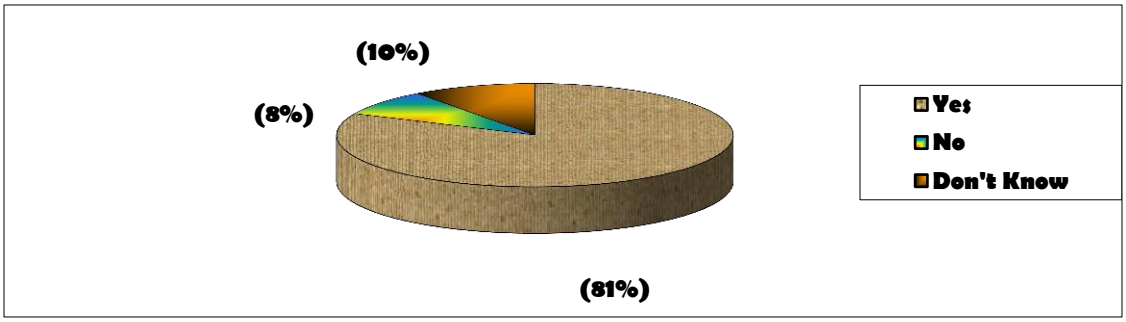

Figure 11: Existence of Tailor-made Products

All the mangers unanimously agreed that health insurance cover existed in the five MFIs. In addition, they were asked to indicate the number covered by sex in the year 2009.The findings was consistent with other findings in this study that demonstrated that the access of health insurance was indeed low in the region.

Table 5: Number covered by gender

Number covered by sex(2009)	Male	% Male covered(of total members)	Female	% Female covered(of total members)	Total
Health Insurance	200	3%	560	9%	6500

4.3.3 Institution Factors

On the question of the institutional challenges facing the MFIs, the managers cited lack of corporate governance structures as one of the institutional factors leading to low access of health insurance. Some of the MFIs were still being run with the NGO mentality and were still

struggling with profitable service delivery. In particular, the credit committees, audit committees, investment committees and risk management committee were all missing in the five MFIs. In addition, the board of directors were not independent of the executive hence the interference in the day to day operations. Poor management and lack of corporate governance structures among MFIs may have contributed to the low access of health insurance in the region.

Lack of awareness of the health insurance products may also be blamed on the MFIs. The MFIs have not done enough to sensitize the people on the existence and benefits of health insurance products. Hence, lack of awareness has led to the low access of health insurance products in the region. The managers also indicated that inadequate donor funds were constraining the operations of the MFIs. Hence the MFIs could not allocate enough funds into awareness building as well as direct disbursements of loans. This in away contributed to the low access of health care insurance.

The state of infrastructure was also an institutional factor that may have led to the low access of health insurance in the region. According to the managers, the region is served by dilapidated roads, poor telecommunication network as well as poor rail network. The poor infrastructure increases the cost and time of access to health insurance. For example, quick access to hospitals is fundamental if health insurance is to work. In addition, the region is served by few and poorly maintained dispensaries and hospitals. Furthermore, the hospitals are not equipped with medical instruments and neither are they stocked with adequate pharmaceuticals. This status quo defeats the whole essence of having health insurance products.

Society as an institution also plays a role in the access of health insurance. According to the managers, the cultural norms and beliefs existing in the region is a big impediment to access of health insurance. For instance, the societal belief of witchcraft was a force to reckon with in the region, not only in health circles, but also taking the economic development of the area into consideration. According to the managers, the respondents also belief that the fundamental basis of health insurance is planning for death or an ill health. This in the Kenyan context is against the norms and the culture of most of the communities. Therefore the managers noted that the culture of the people has been obstacle in the spread of life insurance business in Kenya.

They stated that in the region it was almost a taboo to plan about a future sickness. This is further complicated by the fact that most members are Christians. Christian doctrines emphasize the need to forecast or project a bright future which has no place for such issues like sicknesses or illnesses. Consequently, the social cultural beliefs played a negative role in the access of health insurance products. Kinship as a social factor also had a role to play in the access of health insurance. The managers noted that the members generally rely on the family ties to come to their rescue in times of trouble. The members of the public in the entire region relied on these extended family network using such products as M-Pesa in times of need. These arrangements in a way compete with health insurance products offered by MFIs.

The economic as well as educational institutions also competed against the health insurance products. The managers noted that the members were concentrating so much on taking loans and ignored other products offered by the MFIs. The managers further added that the clients were more concerned with such factors as education of their household members and growth of their businesses than they were concerned with the issue of health. Thus most of their financial initiatives were motivated largely by these two factors; the need to educate their children or the

need to start and expand their business. This finding was consistent to the findings by Preker et al., (2002) and Jutting, (2004) who observed that lack of finances is indeed a key reason why many people do not join or use insurance products. The study findings are also in agreement with several studies (Ram 1994; Ndyomugyenyi, et al. 1998; Sargent, 1985; Bhatia, 2001; Anon, 1997) which have asserted that cultural factors largely affect adoption of healthcare insurance among Africans and are responsible for the low uptake of healthcare insurance products.

4.3.4 Government Policies and Global Influences

The managers noted that regulations were impacting negatively on their business. They noted that the fall of pyramids schemes whereby many members of the public lost huge sums of money have been due to laxity in passing laws to reign on such opportunistic elements in the society. This has affected the MFIs general business as well as the healthcare insurance products .For instance, a substantial portion of the members of public who are potential clients and even existing clients have started viewing MFIs as gamblers who cannot be trusted with their money.

The managers indicated that the government has stood in the way of MFIs in providing health insurance products due to the fact that it had not invested in programs which can strengthen the MFIs in the country. The Finance and Microfinance Bill passed in 2007 is silent on the conduct of MFIs in case they opted to venture into offering healthcare insurance products. The bill has concentrated on the other financials services offered by MFIs.

The managers indicated that the existing legislations do not address issues regarding ownership, governance, and accountability. They have also contributed to a large extent to the poor performance and eventual demise of many MFIs because of a lack of appropriate regulatory oversight. This has had a bearing on a number of other constraints faced by the industry, namely: diversity in institutional form, inadequate governance and management capacity, limited outreach, unhealthy competition, limited access to funds, unfavorable image and lack of performance standards. However, the respondents indicated that this situation has offered flexibility upon which MFIs operate, experimenting with various innovative models of solving the problems of their members at the grassroots' levels. Lack of excessive government patronage has given room for MFIs to maneuver and come up with sustainable models in the communities they operate in.

The managers also pointed-out that the current economic crisis coupled with the Post Election Violence (PEV) that followed the 2007 general election has made it harder for the MFIs and especially the promotion of healthcare insurance products. The economic crisis has led to contraction of the economy and eroded the purchasing power of the public. The Post Election Violence put the overall insurance industry in the limelight with the insurance industry players put into task to come up with ways to compensate their insured who lost their lives and property during the period. The MFIs also suffered immense losses as their employees were killed and their offices destroyed. They also suffered losses as the SMEs most of whom were clients of the MFIs. Some of their clients were also killed during the period. This impacted negatively on the general business of the MFIs. Finally, the global financial meltdown reduced the aggressive lending by all financial institutions including MFIs. The conservative stance adopted by MFIs led to the low access of health insurance products in the region.

5.0 DISCUSSION CONCLUSIONS AND RECOMMENDATIONS

5.1 Findings

The following personal characteristics were found to affect the access of health insurance in Western Kenya. Findings in this study indicated that there is a negative relationship between sex (involvement of women only in MFIs) and access to health insurance. That is, the low involvement of men in MFIs offering health insurance products may have led to the low access of health insurance products in the region. The low level of education negatively affected the access to health insurance. The relationship between marriage status and access to health insurance was not clear. Family size affects the access to health access products. In particular, the existence of large households may have contributed to the low access of health insurance products. The low level of income may have contributed to the low access of health care insurance as most respondents indicated that they could not afford the premiums. The finding implies that there was a negative relationship between religion and the access of health care. Therefore, being predominantly Christian may have led to the low access to health insurance

The study found out that lack of corporate governance structures as one of the institutional factors leading to low access of health insurance. Therefore, poor management and lack of corporate governance structures among MFI may have contributed to the low access of health insurance in the region. The study also found out that that inadequate donor funds were constraining the operations of the MFIs. The poor state of infrastructure was also an institutional factor that may have led to the low access of health insurance in the region. Lack of awareness of the health insurance products may also be blamed on the MFIs. The MFIs have not done enough to sensitize the people on the existence and benefits of health insurance products. The Christian dogma and the cultural belief in witchcraft exacerbated the low access to health insurance in the region. The culture of kinship also led to the slow access of health insurance in the region. The educational and economic institutions did not spare access to health insurance either. They gave competition (financial competition) to health insurance products.

Findings in this study indicate that there lacks clear and concise government policies towards health products offered by micro finance. This had led to the low access of health care products offered by microfinance institutions. MFIs are still reeling from the effects of the 2007 post-election violence. In addition, the economy has never been the same since then. The global financial meltdown has impacted negatively on the access of health products too due to the conservative approach adopted by banks.

5.2 Conclusions

The micro finance sector in Kenya operates under ambiguous and hostile environment, particularly with respect to micro finance clientele who mostly operate from temporary structures. Therefore, access of health insurance products offered by MFIs requires an enabling environment that recognizes the operation of MFIs as well as SMEs. An enabling legal and regulatory environment would go a long way in ensuring that the micro finance industry thrives and is able to empower many low income or poor people who will in turn be able to take improvised products like health care insurance. Local authorities in collaboration with the government on the other hand, need to cultivate harmonious relationships with the SMEs and develop adequate business facilities for rental.

The study concludes that the MFI need to liaise with strategic partners in the grassroots like the churches and schools to raise awareness of the healthcare insurance products. MFIs can play an instrumental role in bringing health services to their clients. Effective health service outreach is a major problem when targeting poor people. MFIs provide regular access to the poor, applicable for health service delivery, particularly those MFIs with group-based delivery mechanisms that meet at regular intervals. This group forum is an appropriate health education service venue. Additional attractive MFI systems include branch locations in poor areas, close client relationships, home site visits and effective health service channels.

5.3 Recommendations

The study recommended that the government and community based organizations should step in and enhance the educational levels of the MFI members. In addition, the community based organizations should emphasize on the need of family planning so as to solve the problem of large households. The study also recommended that MFIs should strive to bring in the men into their net. The study further recommended that the MFIs need to liaise with strategic partners in the grassroots in the regions they operate such as churches and schools to raise awareness of the healthcare insurance products. The MFIs need to institute corporate governance mechanisms such as independent board of directors, audit committees, investment committees, risk management committees among others

5.4 Suggestions for Further Studies

The study recommends that future research be conducted to investigate the specific effect of each of the factors identified in this study. A future study can be for example conducted on the effects of education or culture on the adoption of healthcare insurance products offered by the MFIs. Future research can be conducted in other geographical regions using similar or different methodology to assess the verifiability of the findings of this study. Such a study would confirm or contest the findings of this study.

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