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CAN COMMUNICATION CAMPAIGNS PROMOTE DEMAND FOR HEALTH INSURANCE IN KENYA?

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SHOPS
Strengthening Health Outcomes *through* the Private Sector

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CAN COMMUNICATIONS CAMPAIGNS PROMOTE DEMAND FOR HEALTH INSURANCE IN KENYA?

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ACRONYMS

ART	Anti-retroviral therapy
KSh.	Kenyan Shillings
NASCOP	National AIDS and STI Control Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
SACCO	Savings and credit cooperative organizations
SHOPS	Strengthening Health Outcomes through the Private Sector
USAID	United States Agency for International Development
USD	United States Dollars

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1. INTRODUCTION

The Strengthening Health Outcomes through the Private Sector (SHOPS) project is a five-year global project funded by the United States Agency for International Development (USAID) and the President's Emergency Plan for Aids Relief (PEPFAR). Private health insurance schemes represent opportunities to increase domestic financing for HIV and AIDS. In Kenya, SHOPS demonstrated that with targeted assistance health insurance companies can significantly increase the number of lives covered, including those in need of HIV and AIDS care and treatment (Gatome-Munyua, Chuma, Callahan, and Tayag 2015). However, to be sustainable, the industry must expand their markets beyond the formally employed. This study provides evidence on the potential for a communications campaign to influence the awareness, knowledge, and attitudes toward health insurance of the informal sector.

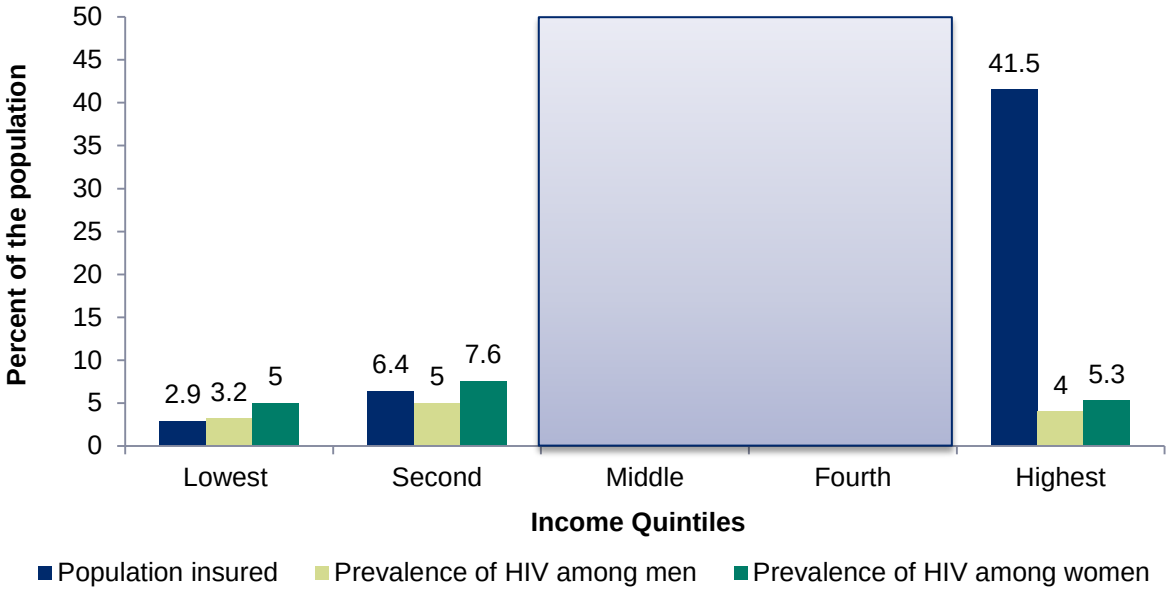
Over the past 10 years. Kenya made significant improvements in HIV care and treatment. HIV prevalence has fallen from its peak of 12 percent in the mid-nineties to approximately 6 percent in 2012 (NASCOP 2014). Rates of testing have also improved with HIV testing among adults and adolescents rising from 34 percent in 2007 to 71 percent in 2012 (NASCOP 2014). However, more work remains to achieve the ambitious UNAIDS global 90-90-90 targets by the year 2020.[1] Using UNAIDS data and assuming stable incidence of 56,000 new infections annually, Kenya could have 1.7 million people living with HIV (PLHIV) by 2020. To achieve the UNAIDS 2020 goal, Kenya will need to increase the number of PLHIV on anti-retroviral therapy (ART) by approximately 1 million while maintaining the more than 744,000 currently receiving treatment. This estimate represents a 134 percent increase in the population of PLHIV receiving ART.

The private sector currently provides close to 25 percent of all ART services in Kenya (NASCOP 2014). Because of this substantial role, increasing access to the private sector should be a priority in responding to stagnant donor funding, uncertain economic growth, and a rising double burden of communicable and non-communicable diseases. HIV prevalence is highest among men and women in the third and fourth income quintiles across Kenya, and in urban areas the fourth and fifth wealth quintiles. These groups have relatively low insurance uptake (12 percent and 25 percent for the third and fourth wealth quintiles (MOH 2014)), despite possessing incomes that can afford strategically priced health insurance products (Tayag, 2013).[2] The green box highlighted in Figure 1, thus represents the opportunity in the health insurance sector to fill the HIV financing gap that the decreasing donor funds will leave.

[1] The 90-90-90 target refers to: By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

[2] This claim is based on SHOPS' prior market research among informal sector workers in these income quintiles that suggests that health microinsurance products with low premiums may be affordable for these populations.

FIGURE 1: HEALTH INSURANCE UPTAKE AND PREVELENCE OF HIV, BY INCOME QUINTILE AND GENDER



Improving the sustainability of health insurance programs will improve access to the private sector, and logically increasing access to private health insurance programs that cover HIV care and treatment can offset costs currently financed by government and donor resources. A recent study noted that Kenyan private insurers have the least exclusions for HIV services compared to their counterparts in sub-Saharan Africa (Talib and Hatt 2013). Furthermore, pooling HIV positive clients with the general population allows for the cross-subsidization of HIV care and treatment supporting domestic resource mobilization.

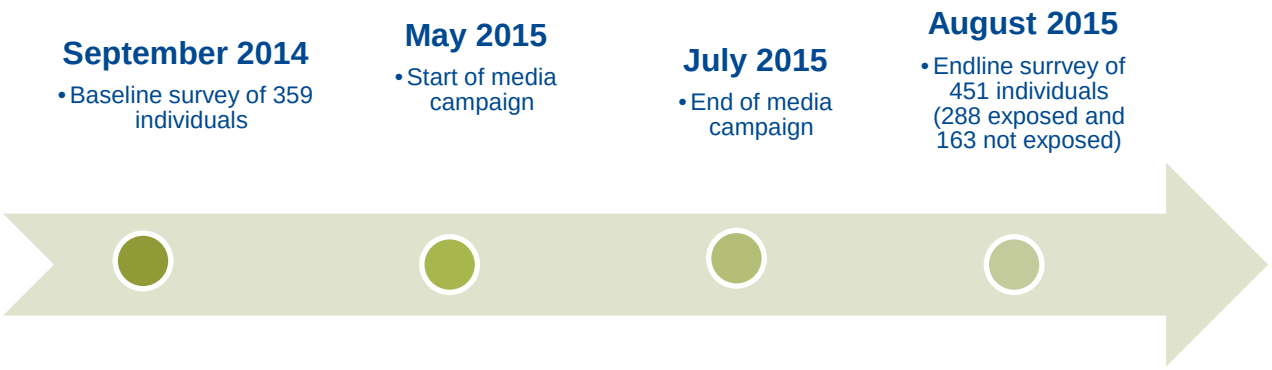
The private health insurance sector in Kenya faces a number of challenges that hinder it from maximizing on its potential to improve access to HIV care and treatment. On the supply side, health insurers are struggling to remain sustainable in light of rising medical inflation, high claims cost, and high administrative costs. On the demand side, the informal sector has had limited experience with private health insurance and thus lacks awareness and knowledge about how products work (Tayag, 2013). A communications campaign may be an effective strategy to influence the broad population. However, health insurance providers should have evidence around the conditions in which communications campaigns may be useful.

2. METHODOLOGY

The study sought to evaluate the impact of a communications campaign on the informal sector's knowledge, value, attitudes towards, and demand for health insurance. The pre-post study randomly sampled a total 810 Kenyans from Nairobi, who were informally employed, earned a household income of between KSh. 8,700 and 26,100 per month, and actively conducted financial transactions with a formal financial institution.[3] Among these, 359 Kenyans were surveyed before the communications campaign and 451 following the campaign. Among the latter group, 64 percent (n=288) were exposed to the media campaign, while the other 36 percent (n=163) were not. In addition to descriptive statistics comparing results from baseline (n=359) and end line (n=288) survey data, the study conducted multivariate regressions to evaluate the above research questions.

Using evidence from the baseline survey, SHOPS developed a communication campaign that targeted potential individual and family insurance clients. The messages also emphasized personal responsibility and disseminated information about health insurance covering HIV and AIDS care, emergencies, and other conditions generally covered by health insurance in Kenya. SHOPS conducted the campaign through television, radio, brochures, bus and wall branding. These channels were supported by a toll-free call center where people exposed to the campaign could call in and receive more information about health insurance, and health insurance products available in the market. The purpose of the campaign was to increase individuals' knowledge, awareness, value, and demand for health insurance. The campaign lasted for two months and was followed by an end line survey a month after the campaign to a randomly selected group of individuals living in Nairobi meeting the same inclusion criteria.

FIGURE 2: TIMELINE FOR THE HEALTH INSURANCE DEMAND CREATION ACTIVITY



[3] Respondents targeted possessed a financial account with a bank, savings and credit cooperative organization (SACCOs), or mobile phone financial service provider, and (d) executed transactions with their accounts at least two times or more per month.

FIGURE 3: EXAMPLE OF CAMPAIGN WALL BRANDING

"Call to action: Get health insurance so as to be responsible. Call 0800-720-234 (Safaricom) and 0800-730-234 (Orange and Airtel) at no cost"

FIGURE 4: EXAMPLE OF CAMPAIGN POSTERS AND FLIERS

"Headline: My family is safe because we have health insurance that covers us all year round. That's being responsible. We are number 1."
"Call to action: Get health insurance so as to be responsible. Call 0800-720-234 (Safaricom) and 0800-730-234 (Orange and Airtel) at no cost."

FIGURE 5: EXAMPLE OF CAMPAIGN BUS BRANDING

"Headline: Be number one."
"Call to action: Get health insurance so as to be responsible. Call 0800-720-234 (Safaricom) and 0800-730-234 (Orange and Airtel) at no cost."

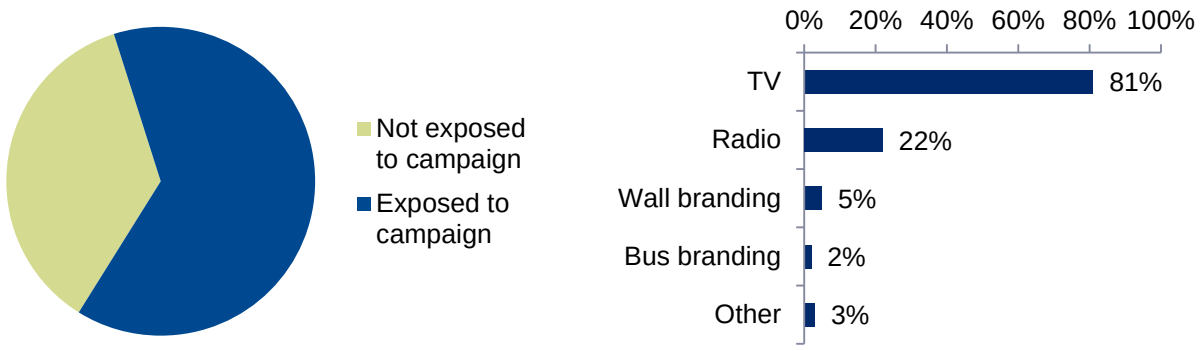
3. RESULTS

In this section results are organized by first providing an overview of the campaign's ability to reach the informal sector, and second, the campaign's effectiveness. Effectiveness is further organized according to influence on knowledge, value, attitudes, and demand towards health insurance. Unless specifically stated, results presented compare the individuals who reported that they were exposed to the media campaign messages during the end line survey (n=288) referred to as "Exposed" and the individuals interviewed during the baseline survey (n=359) referred to as "Not Exposed".

3.1 MEDIA CHANNELS

Per Figure 6, 288 of the 451 individuals surveyed at end line were exposed to the communications campaign – an exposure rate of 64 percent. Among those exposed, roughly 81 percent saw it on television and 22 percent heard it on the radio, suggesting that these are the most effective methods for reaching the target audience. Most of these individuals were exposed four or more times. Excluding these two modes of communication, very few individuals indicated seeing/hearing it elsewhere.

FIGURE 6: PROPORTION EXPOSED TO CAMPAIGN (LEFT) AND TYPE OF MEDIA OUTLET (RIGHT)



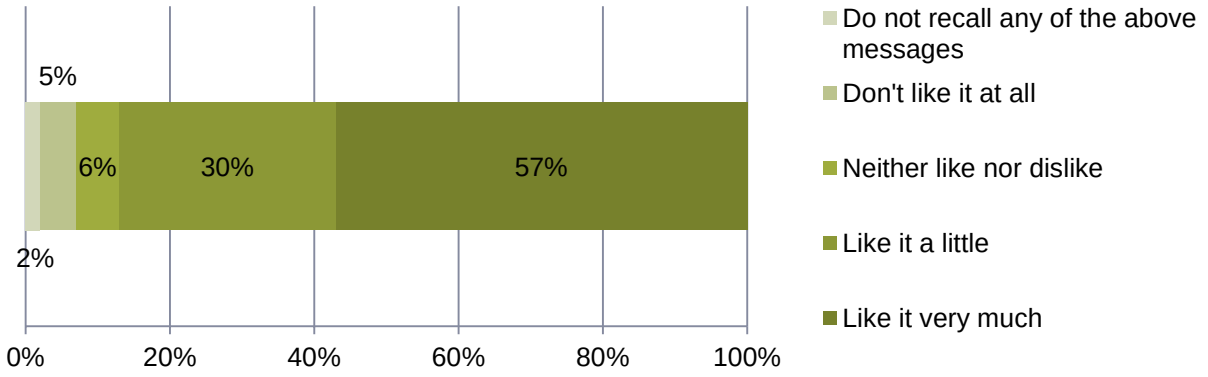
On average, 69 percent of key messages were remembered through prompted recall by those exposed to the campaign (Table 1). Upwards of 89 percent of individuals recall seeing/hearing, "Put your health and your family's health number one. Be responsible." As listed in Table 1, respondents also remembered other messages related to different types of conditions covered, affordability, the importance of protection, and ease of enrollment. The least remembered message (52 percent) related to more complex statements such as, "Health insurance usually covers services like regular doctor's visits and hospitalizations." Only seven percent of exposed respondents did not recall specific messages, which is evidence that the campaign was successful at reaching populations with key messages.

TABLE 1: PERCENT OF RESPONDENTS WHO RECALL CAMPAIGN SLOGANS

Key message	Percent of exposed who remembered the message (n=288)
Put your health and your family's health Number One. Be responsible	89%
Health insurance also covers emergenies, illness, child care, and HIV	76%
Health insurance can be affordable for all types of people	68%
Illness strikes without warning; protect yourself and your family with health insurance	66%
Signing up for health insurance is easy	63%
Health insurance usually covers services like regular doctor visits as well as hospitalizations	52%
Do not recall any of the above messages	7%

Among individuals who were exposed to the campaign, 57 percent indicated liking the campaign very much and 30 percent indicated liking it a little (Figure 7).

FIGURE 7: RESPONDENTS' ATTITUDES TOWARDS THE MEDIA CAMPAIGN



In sum, the campaign reached a large proportion of the target population. A substantial portion of the population remembered the messages and had favorable responses to the campaign. The following sections present whether, and the conditions under which the messages influenced knowledge, value, attitudes, and demand toward health insurance.

3.2 KNOWLEDGE ABOUT HEALTH INSURANCE

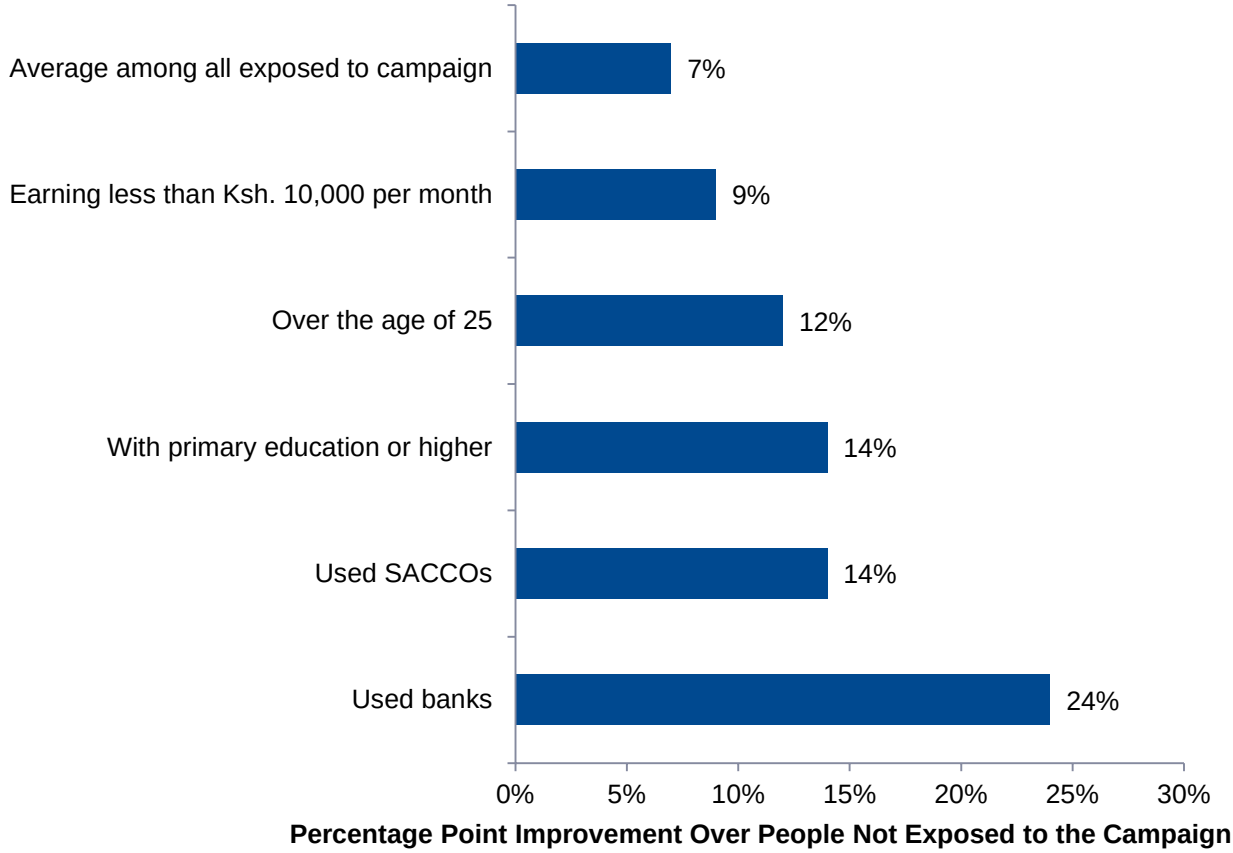
Among individuals exposed to the campaign, 77-87 percent agreed or strongly agreed that:

- The campaign improved their understanding of health insurance (87 percent)
- The campaign corrected their misunderstandings about health insurance (77 percent)
- The campaign told them something new about health insurance (84 percent)

When compared with those not exposed to the campaign, individuals exposed to the campaign had significantly ($p<.01$) greater knowledge of health insurance. On average, exposure to the campaign was associated with performing seven percentage points higher on tests related to knowledge of health insurance. The media campaign had a stronger impact on one's knowledge of health insurance if that individual was more highly educated, used banks or SACCOs, was

older than 25, and earned less than KSh. 10,000.[4] Specifically, those with a primary education or higher experienced a 14 percentage point improvement in health insurance knowledge. The campaign was also associated with a 24 percentage point improvement in knowledge among those who use banks, 14 percentage point among those who use SACCOs, 12 percentage point among those older than 25 years, and a nine percentage point improvement for those earning less than KSh.10,000 (see Figure 8).

FIGURE 8: PERCENT IMPROVEMENT IN KNOWLEDGE AMONG THOSE EXPOSED TO THE CAMPAIGN



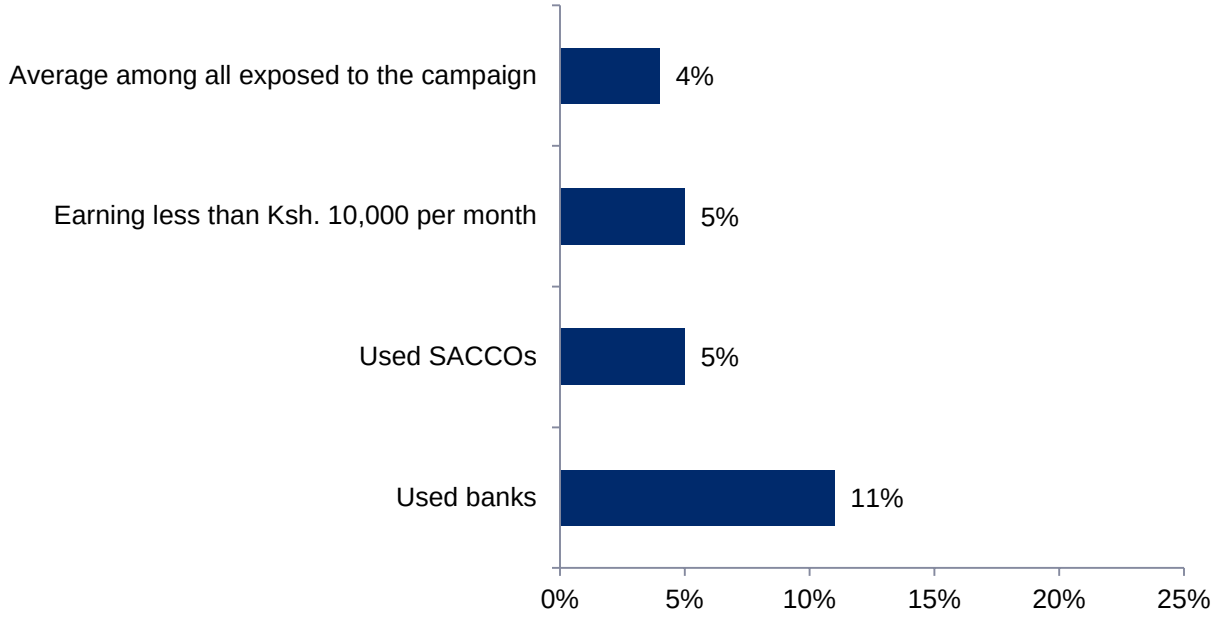
The exposed group performed significantly better on questions addressing the need for health insurance when the probability of an individual's illness is low, such as being young and for catastrophic events. For questions testing knowledge of technical insurance terms (e.g. premiums, reimbursements) not addressed in the campaign, the exposed group actually performed significantly worse than individuals not exposed to the campaign.

[4] An Ordinary Least Squares (OLS) regression was run to evaluate the impact of the media campaign on insurance knowledge, controlling for other factors (e.g. education, age, income); data presented in Figure 8 compared insurance knowledge among each of these factors at baseline (not-exposed to the campaign) with that same factor at end line (exposed to the campaign). For instance, compared with individuals using other financial institutions, the study assessed whether the campaign had a stronger impact on one's knowledge of health insurance if he/she used banks. In statistics, these are called "interaction effects."

3.3 VALUE OF HEALTH INSURANCE

For this study, value refers to the aspects of health insurance that would be useful for potential clients such as financial protection, access to quality care, improved health seeking behavior, and peace of mind. On average, exposure to the media campaign was associated with a significant ($p<.05$) improvement in one's understanding of health insurance's value. Those exposed to the media campaign performed four percentage points better than people not exposed to the campaign on questions designed to assess understanding of the value of health insurance. The media campaign had a much greater effect on one's understanding of health insurance's value if that individual used banks, SACCOs, and made less than KSh. 10,000. Specifically, these groups understood the value of health insurance eleven and five percentage points better, respectively, than those not exposed to the media campaign.[5]

FIGURE 9: PERCENT IMPROVEMENT IN VALUE AMONG THOSE EXPOSED TO THE CAMPAIGN



Questions for which the exposed group performed significantly better included those focused on the value of health insurance at improving financial risk protection, as well as allowing one to focus on quality of care rather than medical costs. Exposed groups scored nine percentage points higher on these aspects of value.

Since possessing health insurance protects people from health care expenses, value may also refer to how people prioritize health care expenses in relation to other household priorities. Respondents were asked to prioritize transportation, savings, food, rent, clothing, school fees, health care expenses, phones, and luxury items. Among all exposed and not exposed respondents, food and rent were consistently among the top two priorities. Roughly 26 percent

[5] Per footnote #4, an Ordinary Least Squares (OLS) regression was run to evaluate the impact of the media campaign on value of health insurance, controlling for other factors (e.g. education, age, income); data presented in Figure 9 compared insurance value among each of these factors at baseline (not-exposed to the campaign) with that same factor at end line (exposed to the campaign).

of individuals who were exposed to the campaign cited health care expenses as one of their top three priorities, compared with only 16 percent of those who were not exposed – a difference of 10 percentage points.

This difference was statistically significant ($p<.01$), whereby being exposed to the campaign was associated with 31 percent greater odds of prioritizing health care expenses. The media campaign had an even stronger impact on one's prioritization of health expenses if that individual had at least a primary education, a higher income, and a larger household.[6]

3.4 INTENTION TO PURCHASE HEALTH INSURANCE

Overall, individuals exposed to the campaign indicated that their intent to purchase health insurance increased as a result of the campaign. Among individuals who were exposed to the campaign, 77 percent agreed or strongly agreed that they were more likely to buy health insurance as a result of the campaign. Furthermore, 70 percent of people exposed to the campaign believed people would likely go buy health insurance because of the campaign.

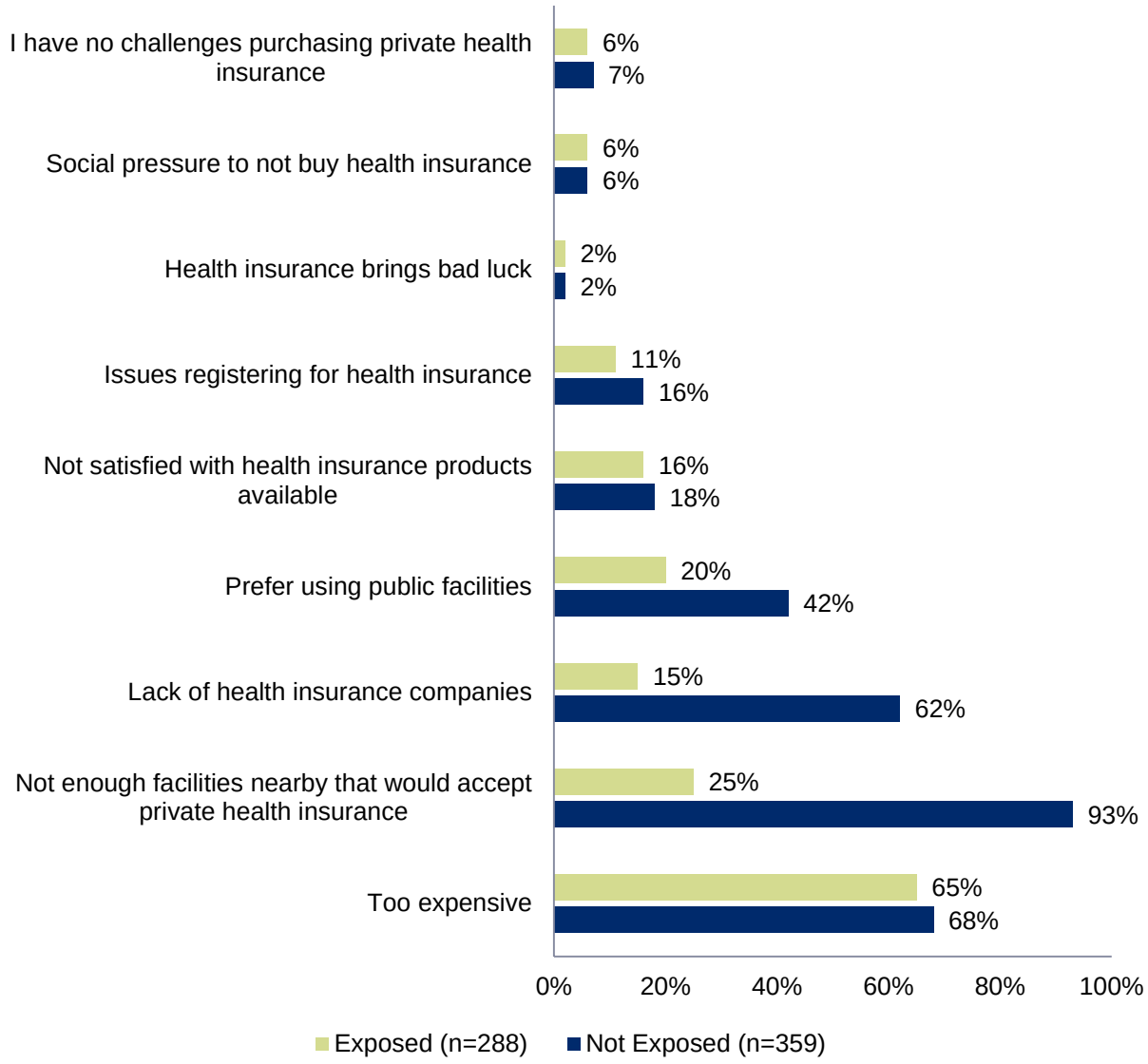
However, cost remains a substantial barrier to actually purchasing health insurance; this is particularly the case for private health insurance. Irrespective of campaign exposure, among those who dropped their health insurance (either PHI or NHIF), 43 percent did so because they couldn't afford to pay the following year's premium. Another 38 percent ceased their health insurance coverage because they had not utilized their health insurance. Among people who had previously had private health insurance, 60 percent ceased their coverage due to cost.

All respondents were asked what factors would hinder them from purchasing private health insurance (Figure 10). Responses among those exposed and not exposed to the campaign were generally similar. The top reason was that private health insurance was too expensive (65-68 percent). Findings suggest that the cost of private health insurance is perceived to be high and a significant barrier to enrollment for both exposed and not exposed groups.

Among those not exposed to the campaign, 62 percent cited the lack of health insurance companies, while 93 percent believed that not enough facilities accepted private health insurance. These figures were significantly less, 15 percent and 25 percent respectively, among those exposed to the campaign. Such dramatic differences across groups suggest that the media campaign may have influenced the perception to concerns about the accessibility or availability of private health insurance products and health facilities. These were issues addressed on radio talk shows and interviews with health insurance practitioners. Other top reasons for both groups included poor satisfaction with existing health insurance products (16-18 percent) and preference for public facilities (20-42 percent).

[6] An ordered logit regression was run to evaluate the impact of the media campaign on prioritization of health care expenses, controlling for other factors (e.g. education, age, income); per footnotes #4 and 5, the analyses compared prioritization of health care expenses among each of these factors at baseline (not-exposed to the campaign) with that same factor at end line (exposed to the campaign).

FIGURE 10: REASONS ONE MAY NOT PURCHASE HEALTH INSURANCE, BY EXPOSURE GROUP



Note: Findings in Figure 10 stem only from self-reported data, among those not exposed to the campaign (baseline) and those exposed to the campaign (end line). No observational data was used or multivariate regressions conducted to obtain these findings.

3.5 HEALTH INSURANCE OWNERSHIP

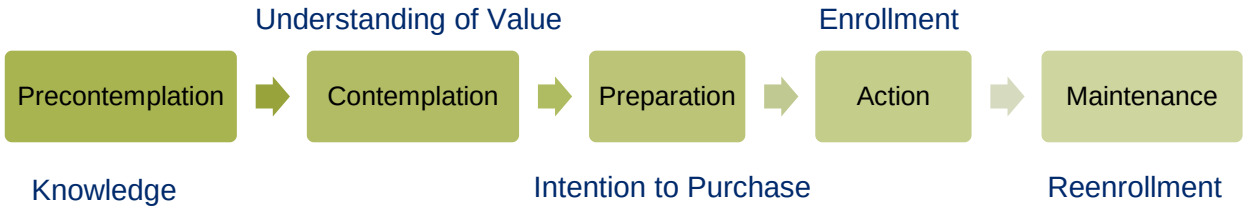
Total health insurance ownership differed by 2 percentage points, whereby 32 percent of those exposed had insurance compared with 30 percent of those not exposed. This difference, despite being small in absolute terms, was statistically significant ($p<.10$).[7] Most importantly, health insurance coverage was higher among individuals with higher incomes.

[7] A logit regression was run to evaluate the impact of the media campaign on health insurance ownership, controlling for other factors (e.g. education, age, income).

4. DISCUSSION

Metrics around knowledge, value, attitudes, and demand toward health insurance map onto the transtheoretical model's stages behavior change (Prochaska & Velicer, 1997). For health insurance, the stages relate to changing how an individual pre-pays for health care as a risk mediating behavior. Before regularly maintaining health insurance, an individual may not prioritize the risk of health care expenditures seriously, which puts his or her household at financial risk. At the first stage, called precontemplation, the person is not aware of the problem and thus has no intention to take action in the foreseeable future. This stage relates to knowledge about health insurance. At the second stage, called contemplation, people are aware of the value of changing their behavior, but may be weighing their costs and benefits of their options. The contemplation stage relates to how a person understands the value of health insurance. At the third stage, called preparation, people intend to take action in the immediate future. For health insurance, this relates to the intention to purchase. The fourth stage is around taking action to change behavior. Relating to health insurance, this is related to the actual enrollment into an insurance program. In the last stage, called maintenance, people continue their behavior, which in our case would be to continue reenrolling or renewing their insurance program (see Figure 11).

FIGURE 11: TRANSTHEORETICAL MODEL'S STAGES OF BEHAVIOR CHANGE



By measuring a communications campaign's influence over knowledge, value, intention to purchase, and enrollment, SHOPS learned that communication campaigns offer an effective means to increase the knowledge and shape attitudes toward health insurance, in addition to prioritization of health care expenditures. Changes in knowledge were highest among more educated lower-income earners, people older than 25 years, and among people who use Banks and SACCOs for financial services. It is likely that more in-depth campaigns are necessary to educate those populations on complex health insurance terms like premiums, copayments, and exclusions.

While results will vary by context, this study found that communication campaigns are most likely to reach the target populations through television or radio. However the cost of communication campaigns such as this is prohibitive to providers of low-cost insurance products. In addition, communications campaigns are a public good further reducing the incentive of insurance providers to invest in such media campaigns. This presents an opportunity for partnerships between public and private agencies (or the insurance regulator) to execute campaigns focused on consumer education.

This study observed significant changes in knowledge, value, and intention to purchase health insurance in response to the campaign. This relates to the communication campaign's capacity to help guide people through the first three stages of behavior change. However, the population had limited ability to take on the act of enrolling in health insurance due, largely, to cost – overwhelmingly the most common challenge reported by people exposed to the campaign.

Cost barriers represent both a demand and supply issue. On the demand side, clients may not have the ability to pay for health insurance products currently available. On the supply side, private health insurance companies may not be marketing affordably designed health insurance products targeting lower-income segments of the population. Through SHOPS' work with a local private insurance company, SHOPS demonstrated that health insurance may be strategically marketed and distributed for the informal sector (Gatome-Munyua, Chuma, Callahan, & Tayag, 2015). However, the private health insurance industry faces pressure to expand their market while reducing administrative costs. Thus, evidence focused on demand-side interventions (such as this study) should be paired with evidence on supply-side interventions.

Specific to HIV, as the economy grows, Kenya must raise resources to meet HIV care and treatment needs of its population and reduce its dependence on donor sources. Health insurance provides an avenue to channel out of pocket expenditure to prepayment schemes. Health insurance can also provide financial protection and guarantee access to care at the time of need for those who can afford to pay, while targeting subsidy to more vulnerable groups of a population.

HIV care and treatment has reduced in cost to approximately USD 250 per person per year.[8] To reach the 90-90-90 goal, more investments are needed as Kenya adopts a test and treat strategy. Providing health insurance products that meet the needs of HIV infected populations can reduce the need for publicly funded or subsidized care while giving them choice of provider and decongesting public health facilities. However, to do so not only requires communications campaigns such as this to address knowledge gaps, but also supporting the supply side to promote the supply and access to affordable insurance products.

[8] PEPFAR 2014 cost of ART care estimates in low- and middle-income countries.

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