Health Spending Behaviour among Low Income Consumers in Kenya: The Myth That "The Poor Can't Pay"

POLICY NOTE SERIES # 15

The Private Sector Innovation Programme for Health (PSP4H) is an action research project funded by the UK's Department for International Development (DFID) tasked with exploring the markets in which poor Kenyans pay for healthcare. Over the past year, PSP4H has conducted extensive research to gain fascinating insight into low income consumer health spending behaviour in Kenya.

Conventional wisdom accepts that the primary reason that low income (*aka* "working poor") Kenyans are underserved by healthcare providers is that they cannot pay for care. Whereas this is true for those below the absolute poverty line who are dependent on public and social services, there is a substantial – and mostly unrecognized – segment of the low income population that can, and does, pay for healthcare. The solid data we have collected shatters the myth that "the poor cannot pay".

The Numbers

***22 million** – the number of Kenyans who currently pay for healthcare from the private sector and are underserved*

***50%** – the proportion of the Kenyan population in this bracket*

***83.3%** – the percentage of the Kenyan workforce in the informal sector*

***61.9%** – the private sector's share of Kenya's total health expenditure*

***76.9%** – the portion of this that is out-of-pocket*

***$45** – Kenya's annual per capital health expenditure*

(Sources: World Development Indicators, PSP4H and others)

How Healthcare Businesses See the Kenyan Population Pyramid

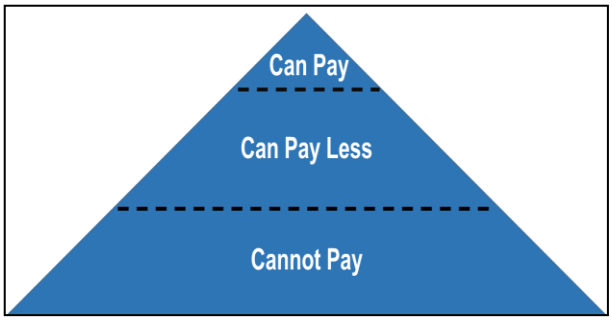

Figure 1: The Kenyan Population Pyramid as Seen by Healthcare Businesses

Commercial healthcare providers segment the Kenyan market into three group of consumers: those at the top who can pay, those just below who can pay less, and those at the bottom of the pyramid who cannot pay. Although the segmentation may prove functional and accurate, many healthcare businesses currently target only the 5% of the population at the top who clearly possess the ability to pay. Consequently, the top end of the market is well-provisioned and well-served.

However, businesses tend to underestimate the size of the "can pay less" segment sandwiched in the middle, incorrectly

assessing that this may only stretch to a further 10% to 15% of the population[1].

PSP4H research puts the actual numbers behind the "can pay less" segment: it is actually **50%** of the population rather than 10% to 15%, a much larger mass of consumers than commercial healthcare providers realise. The figures still consider that only 5% of the population is in the "can pay" group and approximately 45% live below the poverty line and cannot pay[2].

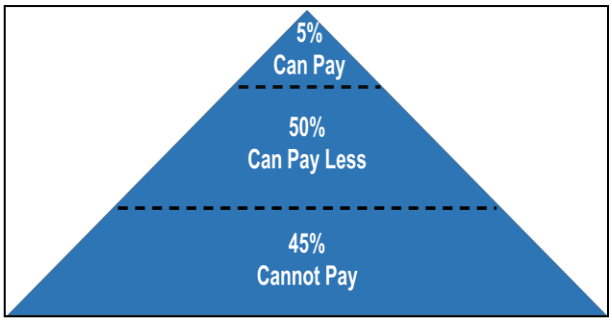

Figure 2: The Kenyan Population Pyramid as Seen by Healthcare Businesses, Percentage

How Many Consumers Can Pay Less?

How many consumers fit in each bracket? Of Kenya's population of forty-four million[3], the 5% at the top number two million, the 45% at the bottom number twenty million, and the 50% "can pay less" segment numbers **twenty-two million** citizens. Such is the massive scale of Kenya's "working poor" segment, an underserved population much too large for businesses to ignore.

PSP4H research shows that Kenya's working poor have an average household disposable income of 100 KSH (rural) to 300 KSH (urban) per day[4] – but the disposable income must cover all household needs, from food to water to school fees to airtime, not just healthcare. Given per capita health expenditures of $45[5] (approximately 4,000 KSH) and average household size of 5[6], mean annual household healthcare expenditure totals 20,000 KSH, which represents just over 50 KSH per day. Such figures fit surprisingly well within the average household disposable income for a working poor family. The problem working poor Kenyans face actually involves liquidity or cash flow, not an absolute inability to afford services. "The poor pay for the service they need at the time they need it."

Working Poor Expenditure is mostly Out-of-Pocket

The informal sector workforce represents 83.3% of the total Kenyan workforce[7]. Unfortunately, few informal workers opt into the government's National Hospital Insurance Fund (NHIF) and only 2% of all workers carry private health insurance[8], primarily those who have formal employment. Therefore, the reality is that Kenya's working poor are largely uninsured, particularly for outpatient services. When low income Kenyans access healthcare through the private sector, they pay out-of-pocket (OOP).

The Private Sector Dominates Health Expenditure in Kenya

Current World Development Indicators show that 61.9% of healthcare expenditure in Kenya is private[9]. The figure stands in stark contrast to the popular assumption that healthcare is largely driven by public spending. The same source shows that an overwhelming 76.9% of private expenditure is OOP. This means that 47.6% of total health expenditure in Kenya is private OOP. This hefty proportion of

Ability to Pay

- *2 million Kenyans are at the top of the income pyramid and have clear ability pay for healthcare from the private sector.*
- *At the base of the pyramid are 20 million who live below the absolute poverty line and cannot pay.*
- *What is seldom recognized is that are **22 million** lower-income Kenyans in between who "can pay less" – and indeed are paying out-of-pocket for healthcare now.*

healthcare spending largely falls on the shoulders of Kenya's working poor since they are uninsured.

It is highly probable that the absolute value of the money spent on healthcare by the working poor segment outstrips that spent by those at the top end of the market. PSP4H encourages further study to quantify this probability.

The problem, well-documented by PSP4H research and elsewhere, is that low income Kenyans live their lives underserved with quality healthcare goods and services and simultaneously receive poor value for the money they actually do spend in the private sector, a phenomenon known as "The Poverty Penalty"[10]. Low income consumers tend to pay a premium for treatment because of a variety of identified factors revolving around the informality of the system through which they seek care, ranging from unqualified and unregistered providers to frighteningly substandard medicine quality.

The Working Poor Prefer the Private Sector

Despite the obstacles, Kenya's working poor strongly prefer the private sector for healthcare[11]. Although financial constraints are conventionally cited as the reason that low income Kenyans do not have better access to healthcare, recent PSP4H research on maternal health (MNCH) interestingly casts doubt on this assumption. In a survey of 435 working poor households in peri-urban areas of Nairobi, only 24.9% of the respondents

Figure 3: Private Midwives' MNCH Supplies

reported that they failed to access necessary services due to financial constraints. The proportion is actually less than the 30% of U.S. adults who say that they, or a family member, put off medical treatment in the past year because of the cost[12]. The same survey showed that price ranked only fifth out of eight factors that influenced the choice of an MNCH health facility, and only 9.6% said affordability was the primary reason for choosing a facility.

Summary Findings

- Kenya's working poor healthcare consumers:
  - Currently pay out-of-pocket
  - Prefer the private sector
  - Do not always cite cost as the primary barrier to access
  - Like any consumers, expect value for money (VfM)
  - Do not currently receive VfM and in fact pay a 'poverty penalty'
- Twenty-two million Kenyans survive in this underserved segment
- Private healthcare businesses who recognize these factors and reach the working poor with better value will tap into a huge market *that has money to spend*
- MYTH BUSTED – the poor cannot pay. **They are paying now.**

Solutions

In order to understand how healthcare practitioners and entrepreneurs can tap into the grossly underserved "can pay less" consumer market, PSP4H works with private sector providers on supply-side solutions that deliver better value to low income consumers. PSP4H involvement primarily focuses on lower cost delivery models or networks that assure better quality of care. This less-utilized approach increases access to quality care for consumers regardless of their financial status, since there is greater demand elasticity at the bottom of the market.

The liquidity problem, especially among the working poor, has been more intransigent as it

Figure 4: A Private Pharmacy in Nairobi

involves long-standing behavioural patterns that reach beyond quantitative economics alone. Successful pro-poor models are likely to match pricing to existing spending patterns, which are closely tied to daily income, instead of requiring new spending behaviours. PSP4H explores both savings and insurance-based models as well as technology-enabled models on the demand side, since the solution largely involves *organizing* finances as opposed to *providing* finances.

In conclusion, the gap between demand and supply for the twenty-two million Kenyans classified as working poor presents a great opportunity for private healthcare providers.

[1] PSP4H interviews with private providers
[2] Private Sector Innovation Programme for Health (PSP4H). 2014. *What Do We Know About the Kenyan Poor and Their Use of the Private Health Sector?* Nairobi: PSP4H
[3] Population, total. Accessed 18 November 2014 <http://data.worldbank.org/indicator/SP.POP.TOTL>
[4] Kenya National Bureau of Statistics (KNBS) and Society for International Development (SID). 2013 *Exploring Kenya's Inequality: Pulling Apart or Pooling Together? National Report*. Nairobi, Kenya: KNBS and SID.
Private Sector Innovation Programme for Health (PSP4H). 2014. *A Formative Survey of the Private Health Sector in Kenya in the Context of the Working Poor.* Nairobi: PSP4H
[5] Health expenditure per capita (current US$). Accessed 18 November 2014 <http://data.worldbank.org/indicator/SH.XPD.PCAP>
[6] Kenya National Bureau of Statistics (KNBS). 2008. *Well-Being in Kenya: A Socioeconomic Profile*. English Press Limited.
[7] Muiya, B & Kamau, A. 2013. 'Universal Health Care in Kenya: Opportunities and Challenges for the Informal Sector Workers', *International Journal of Education and Research*, Vol. 1, No.11
[8] PSP4H estimate based on interviews with private providers
[9] Health expenditure, public (% of total health expenditure). Accessed 18 November 2014 <http://data.worldbank.org/indicator/SH.XPD.PUBL/countries>
[10] Private Sector Innovation Programme for Health (PSP4H). 2014. *Qualitative Research: The Working Poor's Difficult and Costly Path to Healthcare in Kenya*. Policy Note Series No. 3. Nairobi: PSP4H
[11] Private Sector Innovation Programme for Health (PSP4H). 2014. *A Formative Survey of the Private Health Sector in the Context of the Working Poor*. Nairobi: PSP4H
[12] Costs Still Keep 30% of Americans From Getting Treatment 2013. Accessed 18 November 2014 <http://www.gallup.com/poll/166178/costs-keep-americans-getting-treatment.aspx>