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Sustainable Health Financing Strategy Initiatives and Universal Health Coverage in Kenya

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ABSTRACT
Achieving universal health coverage (UHC) has become a dominant health policy preoccupation within the global community, requires substantial resourcing and sustainable financing mechanisms. In Kenya, however, insufficient funding for the health sector coupled with an increase in growth of the population has limited the ability of the government to realize UHC in Kenya. However, with the government still focused on achieving UHC against the budget shortfalls, a sustainable health financing strategy would be imperative. Therefore, the aim of this paper is to establish the influence of sustainable health financing strategies on achievement of UHC in Kenya. The study adopted a descriptive research design targeting UHC stakeholder organizations including the Ministry of Health, public and private social health insurers, donor fund agencies, as well as public and private healthcare providers in the country. From these, a sample size of 234 organizations were selected using mixed sampling techniques to participate in the study. Data was collected through questionnaires and interview schedules. Data was analyzed using descriptive statistics and inferential statistics, that is, bivariate linear regression analysis. The study found that sustainable health financing strategy had a significant relationship with the achievement of the Universal Health Coverage in Kenya. The study recommends that the UHC policymakers and implementers need to consider a range of sustainable health financing schemes that have high penetration rates and low volatility.

Keywords: universal health coverage, health policy, insufficient funding, sustainable health financing strategies

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I. Introduction

Healthcare is one of the most essential human requirements, and its disbursement should be addressed with the requisite sensitivity to prevent loss of life and decrease in human capital (Wangia & Kandie, 2018). Universal Health Coverage (UHC) is, therefore, a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequities for shared prosperity of any nation. Achieving universal health coverage (UHC) has become a dominant policy preoccupation within the global health community. The objectives of WHO on Universal Health Coverage are equity access to health services which states that not only those who can access funds for the care services should get the services but also those who need them.

Moreover, the care services quality should be sufficient to recuperate the health of those getting the services and protection against financial risk by making sure that the cost of using health care services does not put people at risk of financial constraints. Therefore, the principal aim of UHC is to reduce the high dependency on out-of-pocket(OOP) payments in the form of user charges and co-payments, which are regressive as they disproportionately affect the poorest in society and, therefore, challenge the underlying tenets of equity within healthcare systems (Ezeoke, Onwujekwe & Uzochukwu, 2012; McKee et al., 2013). According to the WHO (2013) estimates, in every year the out of pocket payment for health care services pushes around one hundred million people below the poverty line.

Various international and regional organization including the World Bank, United Nations, Gates Foundations among others have also endorsed UHC and promoted the move towards universal health coverage (Bristol, 2014 & Clark, 2014). In addition, Universal Health Coverage is WHO's priority goal and also a primary objective for health reforms in many countries, Kenya included (in one of the Big Four Agendas). In recent years there has been a trend for many developing countries to move towards a new or expanded role for various forms of social health insurance (SHI), in the pursuit of universal health care as championed by the World Health Organization (WHO, 2010). For Africa, progress towards UHC involves ambitious goals for expanding access to a range of effective health services, a substantial increase in health expenditure, and establishing a greater reliance on prepayment and pooling mechanisms to finance healthcare (WHO, 2010). The Kenyan UHC program under the country's Big Four Agenda began in 2018 as a pilot program in four of Kenya's 47 sub-national governments (Ministry of Health of Kenya 2018).

Achieving UHC, however, requires substantial resourcing and sustainable financing mechanisms. According to one set of calculations, achieving UHC requires countries to spend at least $86 per capita in 2012 dollars on healthcare, and a minimum of 5% of Gross Domestic Product (GDP) (Mc Intyre, Meheus & Røttingen, 2017). Clearly, expanding the 'fiscal space for health' will be key to the success of UHC (Heller, 2016). In April 2001, the African Union countries met in Abuja, Nigeria and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support. However, data from the World Bank (2022) indicates that almost two decades after the declaration, the average spending by Sub-Sahara countries as a percentage of Gross Domestic Product (GDP) has fallen below the pre-Abuja Declaration levels, that is; from 5.4% in 2000 to 4.59% in 2019.

In Kenya, the current government spending on healthcare oscillates between 4% & 6% which is very low when viewed against the 12% recommended in the Kenya Health Sector Strategic Plan, and the 15% in the Abuja Declaration which Kenya is a party to (Oraro-Lawrence & Wyss, 2020; Mwaniki & Ogoti, 2022). The underfunding reflects a trend in the government's healthcare spending which means it cannot comfortably meet its UHC obligations without additional financing from elsewhere. Evidently, this leads to a significant healthcare provision gap that cannot be met by the government and its development partners alone to the extent that out-of-pocket payments can be completely abolished in the public healthcare facilities. Consequently, the government has activated the second phase of the UHC which is the rollout of a social health insurance scheme through the National Health Insurance Fund NHIF (Kiarie, 2022).

This is, however, challenging given the low coverage of the population under the National Health Insurance Fund (NHIF). NHIF is a contributory health insurance scheme and the proposed vehicle for delivering UHC across the entire population. It is mandatory for formal workers but voluntary for informal workers. Currently, approximately 20% of the country's population have some form of health insurance with 75% of these being formal workers while 25% being informal sector workers. NHIF constitutes the bulk of health coverage at 15.8% coverage which translates to 80% of the population with some form of insurance (Kazungu & Barasa, 2017). According to the Institute for Global Health Sciences (2019), NHIF's coverage among informal workers who form 83% of the Kenyan workforce remains dismally low, with only 17.7% of the population is estimated to be covered by the scheme. Therefore, the low social health insurance subscription coupled with the insufficient government funding of healthcare through taxes, it is not quite possible to guarantee the sustainability of financing UHC.

Sustainable health care financing is an important element laid down in the Health Sector Plan (2013-2017). Beyond ensuring sufficient resources to support the full functioning of the health system, sustainable health financing also refers to the efficacy of such funding in protecting the population from financial risks in accessing the health services they require (Kutzin, 2013). Sustainable health care financing ensures that all people access health in the country. However, insufficient funding for the health sector (low budget allocation from the government) coupled with an increase in growth of the population has limited the ability of the government to realize UHC in Kenya. The health care sector has continually been financed by sources from the private sector including the amount raised by households at individual level. Thus, a lot has to be done by the government for sustainable health care financing which would result into UHC in Kenya.

Some of the steps to be taken include partnering with development agencies and partners including the World Bank establish new and innovative ways and channels of financing health care in Kenya. The establishment of NHIF was seen as a means of ensuring the funds are pooled together from development agencies, partners and the government. This was also meant to ensure that funds are availed directly to healthcare centers so that they can effectively implement their plans (Yu, 2015). Oketch and Lelegwe (2016) analysed UHC and equity and how they influence accessibility to health care in Kenyan context. The study pointed out issues concerning governance at NHIF that that include corruption and collusion at NHIF and facility levels have adversely realization of sustainable health care financing and thus negatively impacting on attainment of UHC. Evidently, from the foregoing discussions, sustainable health financing strategies are

needed for UHC. However, there is scant literature relating sustainable health financing strategies with UHC in Kenya, and this was the motivation for the current study.

II. Materials and Methods

The study adopted a descriptive cross-sectional survey research design targeting multiple UHC stakeholder organizations in the healthcare industry comprising of policy makers and implementers (at the National and County Health Ministries), financiers (both NHIF and Private Insurance firms), donor fund agencies, as well as public and private healthcare providers in the country. This was owing to the fact that UHC in Kenya is meant to be delivered strategically through a multi-sectoral approach comprising both government and private sector actors. In total, the number of organizations targeted throughout the country was 565. The unit of observation consisted of the management in the organizations as they are the key decision makers entrusted with the policy interpretation and implementation function. Respondents from the national and private medical insurance providers were selected using systematic random sampling while purposive sampling were used to select respondents from the international donor funds and national ministry of health. A sample size of 234 UHC stakeholder organizations was obtained using the formula proposed by Israel (2009). The sample size was then proportionally allocated across the implementing organizations size using he Neyman allocation formula.

The study used both primary and secondary data. Primary data collection was done using a questionnaire and an interview schedule which was administered to management of the organizations. The items in the instruments were derived from constructs generated through literature survey on sustainable financing and UHC. Secondary data was collected in form of official records on UHC. To improve on the internal validity of the study, a pilot test of the instruments was done to detect design weakness in the instrumentation for primary data. This exercise was meant to assess and refine the instruments before administering in the actual study population. The purpose of pilot testing is to establish the accuracy and appropriateness of the research design and instrumentation (Saunders, Lewis & Thornhill, 2007). Regarding the constructs used in the instrument, that no construct fell below the communality value of 0.49 which is the accepted threshold value recommended by Lawshe (1975). The test of reliability of the questionnaire also showed high internal consistency with values exceeding the Cronbach threshold value of 0.7.

The qualitative data was analyzed using descriptive methods involving content analysis and coding with the aid of the Nvivo software. This makes it possible to analyze the latent and manifest textual material through classification, tabulation, and evaluation of its key symbols and themes in order to derive their meanings and probable effect on the subject under investigation (Krippendorff, 2004). Quantitative data was analyzed by use of the Statistical Package for Social Scientists (SPSS). Descriptive statistics involved frequencies as percentages as well as the chi square to provide the general trends of the data. Inferential statistical analysis, on the other hand, involved bivariate correlations and multiple regression analysis.

III. Results

3.1 Effect of sustainable health financing strategy on achievement of Universal Health Coverage in Kenya

The objective of the study was to find out the effect of sustainable health financing strategy on Universal Health Coverage in Kenya. This objective was measured on the basis of; Compulsory prepayments, Voluntary Prepayments, Out of pockets payments and NHIF. The results are summarized in Table 1.

Table 1: Sustainable health financing strategy and Universal Health Coverage in Kenya

Statement .	SD f(%)	D f(%)	N f(%)	A f(%)	SA f(%)	. x2	. p-value
The government is efficiently directing and using funds ensure equitable access to quality health services and financial protection for all.	28(15)	74(40)	12(6)	51(27)	22(12)	108.88	0.011
The government is strengthening and aligning PFM systems that determine how budgets are formulated, allocated and executed with health financing functions and health system objectives	0	46(25)	41(22)	79(42)	21(11)	77.32	0.062
Efficient and sustainable financial policies have been put in place by the government to enhance universal health coverage	14(7)	76(41)	33(18)	50(27)	14(7)	95.73	0.015
Strategies have been put in place to raise revenues that can sustainably finance universal health coverage in Kenya	44(23)	50(27)	18(10)	40(21)	35(19)	80.83	0.003
Spending targets have been put in place for the health sector to ensure sustainable financing	0	6(3)	43(23)	93(50)	45(24)	74.25	0.031

Health coverage schemes have increased access to health services for all citizens	32(17)	77(41)	11(6)	56(30)	12(6)	67.68	0.044
Health coverage schemes assures availability of quality health services among insured individuals in the country	4(2)	25(13)	68(36)	73(39)	17(9)	61.10	0.034
Monthly premium improves personal health seeking behavior	9(5)	48(26)	44(23)	67(36)	19(10)	54.53	0.035

Table 1 shows that 40% of the respondents disagreed while 15% strongly disagreed implying that the government was not efficiently directing and using funds ensure equitable access to quality health services and financial protection for all. However, there are indications that the government is strengthening and aligning PFM systems that determine how budgets are formulated, allocated and executed with health financing functions and health system objectives as suggested by most of the respondents, 42% of who agreed and 11% who strongly agreed. Further, most respondents 47% of who disagreed and 7% who strongly disagreed that efficient and sustainable financial policies have been put in place by the government to enhance universal health coverage.

Also, there are indications that not enough strategies have been put in place to raise revenues that can sustainably finance universal health coverage in Kenya as indicated by most of the respondents, 27% of who disagreed with the statement and 23% who strongly agreed. However, spending targets have been put in place for the health sector to ensure sustainable financing as implied by most respondents, 50% of who agreed and 24% who strongly disagreed. Further, 41% of the respondents disagreed while 17% strongly disagreed that with the view that health coverage schemes have increased access to health services for all citizens. The respondents, however, indicated that for the in insured individuals in the country, health coverage schemes assure availability of quality health services as suggested by 39% who agreed and 9% who strongly agreed. The findings also suggest that monthly premium improves personal health seeking behavior among the citizens as indicated by most respondents, 36% who agreed and 10% who strongly agreed.

3.2 Achievement of Universal Health Coverage in Kenya

The study finally sought to determine the status of the achievement of universal health coverage in Kenya. This was the dependent variable and was measured on the basis of; access to healthcare, affordable health care financing and sufficient health staff capacity. The results are summarized in Table 2.

Table 2: Status of Achievement of Universal Health Coverage in Kenya

Statement .	SD f(%)	D f(%)	N f(%)	A f(%)	SA f(%)	. x2	. p-value
Health financing as a key policy instrument for the government of Kenya has helped to reduce health inequalities	20(11)	34(18)	30(16)	61(33)	42(22)	87.34	0.046
There is improved equity in access to primary healthcare services	2(1)	31(17)	50(27)	85(45)	19(10)	111.39	0.083
There is improved equity in access to healthcare services for chronic conditions	16(9)	48(26)	31(17)	62(33)	30(16)	99.83	0.020
There is adequate coverage of diagnostic services	20(11)	67(36)	35(19)	43(23)	22(12)	112.02	0.050
There is improved effectiveness and efficiency of healthcare services delivery	5(3)	56(30)	33(18)	84(45)	9(5)	118.26	0.037
We operate on the principles of equity and sustainability.	35(19)	36(19)	16(9)	77(41)	23(12)	124.51	0.032
The healthcare service providers get adequate allocation per patient per day to cover for the management of most conditions	26(14)	82(44)	18(10)	43(23)	18(10)	130.76	0.026
The healthcare service providers get their capitations in a timely manner	17(9)	79(42)	32(17)	48(26)	11(6)	137.00	0.021
We have challenges with reconciliations of the capitations across the healthcare service providers	8(4)	58(31)	27(14)	81(43)	13(7)	143.25	0.016

The results in Table 2 show that health financing as a key policy instrument for the government of Kenya has helped to reduce health inequalities as indicated by 33% who agreed and 22% who strongly agreed. Majority of the respondents, 45% of who agree and 10% who strongly agreed suggested that that there is improved equity in access to primary healthcare services. There were also indications that there was improved equity in access to healthcare services for chronic conditions as indicated by 33% who agreed and 16% who strongly agreed compared to 26% who disagreed and 9% who strongly disagreed respectively. However, coverage of diagnostic services was not adequate as indicated by most of the respondents (36%) who disagreed and 11% who strongly disagreed. Nevertheless, most of the respondents agreed (45%) while 5% strongly agreed that there was improved effectiveness and efficiency of healthcare services delivery.

The healthcare services were also being operated on the principles of equity and sustainability as indicated by most of the respondents (41%) who agreed and 12% who strongly agreed. However, most of the respondents felt that the healthcare service providers get adequate allocation per patient per day to cover for the management of most conditions as indicated by 44% who disagreed and 14% who strongly disagreed. Further, most of the respondents (42%) disagreed while 9% strongly disagreed that the healthcare service providers get their capitations in a timely manner implying that there was dissatisfaction with the way capitations were being done to the healthcare service providers. In addition, challenges were being experienced with reconciliations of the capitations across the healthcare service providers as indicated by most of the respondents who agreed (43%) and 7% who strongly agreed.

3.3 Regression analysis of sustainable health financing strategy on achievement of Universal Health Coverage in Kenya

Bivariate regression analysis was carried out to evaluate the relationships between the dependent and independent variable. The findings are summarized in Table 3.

Model Summary	R	R Square	Adjusted R Square	Std. Error of the Estimate		
	0.423	0.178929	0.159426	3.557821		
ANOVAa		Sum of Squares	df	Mean Square	F	Sig.
	Regression	54.554	1	54.554	4.309814	.05
	Residual	2303.772	182	12.65809		
	Total	2358.326	183			
Model Coefficients		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	40.376	3.992		10.114	0
	Health Financing	0.497	0.161	0.423	3.086957	0.05

a Dependent Variable: Universal Health Coverage

The results in Table 3 indicates that the relationship was significant and moderate ($\beta = 0.423$; $p = 0.000 \leq 0.05$). This implies that creating sustainable financial mechanisms of healthcare were instrumental to the achievement of UHC.

3.4 Qualitative Analysis of Sustainable Health Financing Strategy on Achievement of Universal Health Coverage in Kenya

Using data captured in both the open ended parts of the questionnaire and the interview schedule, the study derived themes emerging from the responses concerning health policies strategy in different healthcare service provider organizations in particular whether they agreed or disagreed with the questions posed and their reasons for their positions on the issues raised. The findings are presented and discussed as follows.

Table 4: Results on Sustainable Health Financing Strategy on Achievement of UHC in Kenya

Do compulsory prepayments affect the universal healthcare program delivery by your organization?
Yes, but that has been working only for those in formal employment. While the subscribers have been getting healthcare coverage, I don't think that has been happening for the uninsured group. Therefore, I can't fully say we have a universal healthcare program
No, I am not seeing any difference as yet. The compulsory deductions just work for those salaried workers and they do not constitute the majority of the population
No, there is no universality in the compulsory prepayments yet
Compulsory prepayments would be a good idea but only if it was possible to have everyone subscribe. But with the current situation, that's an impossibility
What about voluntary prepayments, do they affect the universal healthcare program delivery by your organization?
Yes, many customers/members are covered and able to access services
Yes, we are now seeing more people coming under the universal healthcare program based on their own subscription

Yes, especially for the elderly, their numbers have increased and I attribute that to their family members making the subscriptions for them
We are currently providing healthcare services to a growing segment of the population in our area that was previously unable to afford our services
No, the voluntary contributions still leave out the very poor who cannot afford the subscriptions
The is more that needs to be done to encourage voluntary prepayments by different insurers
No, I don't think subscriptions alone be it mandatory or voluntary will address the universal healthcare needs, I believe healthcare should be made more accessible and affordable in the long term so that even those in out-of-pocket modes can still enjoy quality and affordable healthcare services
What is your view of out of pocket payments, does it improved the universal healthcare program in your organization?
Out-of-pocket-payments are pretty much straight forward as no capitation is involved. However, it is so limited sometimes and patients seldom afford the full range of services available or prescribed
No, out-of-pocket-payments cannot really get us to universal healthcare. It has been the mode but with disastrous results.
No, we cannot have out-of-pocket-payments and universal healthcare at the same time
Yes, only is out-of-pocket-payments requirements in health services are very limited
Even in the highly subsidized public healthcare facilities, out-of-pocket-payments is still a problem

From Table 4, it is evident that the achievement of universal healthcare program was largely viewed in terms of capitation. Out-of-pocket payment also scored as the second most relevant item while compulsory prepayment and subscription were also ranked as among the most relevant issues affecting the implementation of universal healthcare. The affordability of the healthcare services and subsidized public healthcare were also rated as among the most relevant issues. However, the state of the public healthcare facilities and their ability to provide a range of services in accordance to the UHC was also a cause for concern.

3.5 Discussions

The findings in Table 3 indicate that there was significant relationship between sustainable financial mechanisms of healthcare and the achievement of UHC. This implies that creating sustainable financial mechanisms of healthcare were instrumental to the achievement of UHC. This finding agrees with Kutzin, (2013) that a sustainable health financing system is fundamental to establish UHC in the developing countries. The establishment of a good health system is fundamental to ensure a sustainable UHC. The investment on health to ensure the sustainability, particularly health voucher programs to increase the demand for maternal and neonatal health services has reduced mortality in the developing countries (Chowdhury et al., 2011; ZZaman & Hossain, 2017).

The findings in Table 1, however, suggested that the government was not efficiently directing and using funds ensure equitable access to quality health services and financial protection for all. This agreed with Oketch and Lelegwe (2016) whose analysis of UHC and equity and how they influence accessibility to health care in Kenyan context pointed out issues concerning governance at NHIF that that include corruption and collusion at NHIF and facility levels have adversely realization of sustainable health care financing and thus negatively impacting on attainment of UHC. Despite NHIF being the largest risk pooling system in the country, only 18% of the total population are covered under the insurance scheme (Barasa et al., 2018a).

The NHIF largely covers the formally employed population, while the poor and disadvantaged comprising around 46.6% of the population are not covered, resulting in appalling health expenses posing an enormous threat on their financial security. However, due to a number of corruption allegations, mismanagement, poor capacity, inefficiency, and weak governance and accountability mechanisms; stakeholders doubted the NHIF's capacity to deliver UHC in Kenya (GOK, 2016). The findings also suggest that not enough strategies have been put in place to raise revenues that can sustainably finance universal health coverage in Kenya. The issue of having the right funding mix has been a challenge even to health systems rated as the most efficient. For instance, Lim (2017) study in Singapore revealed that despite the expansion of funding and services, the government remains committed to the longstanding principles of fiscal prudence and not drawing from past reserves.

It was also evident that while health coverage schemes have not necessarily increased access to health services for all citizens. For the in insured individuals in the country, health coverage schemes assure availability of quality health services. According to Barasa et al, (2018b) whose study on NHIF reforms and its implications and Lessons for Universal Health Coverage, Health Systems & Reform, showed that since 2010, there has been an expansion of the coverage to include various segments of the society. However, though NHIF

reforms in Kenya are well intentioned and there has been improvement in several areas, design attributes could compromise the extent to which they achieve their intended goal of providing universal financing risk protection to the Kenyan population. Kyomugisha et al., (2009) in Uganda, however, found that there were challenges with equity in the provision of healthcare. Citizens without cover were treated better in hospital than members; some members pay premiums continuously without falling sick and schemes refused to cover illnesses like diabetes and hypertension. Fairness was related with the very little payment for the services received, members paying less than non-members but both getting the same treatment and no patient discrimination based on gender, age or social status.

The results implied that health financing as a key policy instrument for the government of Kenya has helped to reduce health inequalities as indicated by most respondents. This disagrees with Barasa et al., (2018b) who observed that whereas the NHIF pays an annual capitation rate of 2,850 KES for members of its CSS, it pays the same facility an annual capitation rate of 1,200 KES for outpatient care for the general population. Similarly, whereas the NHIF reimburses the full cost of delivery for the civil servants based on a fee-for-service payment mechanism, it pays the same facility 10,000 KES per delivery for members in the national scheme using a case-based payment system. Mbau et al., (2018) also noted that these multiple provider payment mechanisms and payment rates may generate conflicting and unwanted incentives for providers. There is evidence that these incoherent provider payment mechanisms have resulted in preferential treatment of civil servants at the expense of non–civil servants. This includes practices like sending non–civil servant NHIF members to purchase medicines from private pharmacies outside the hospital using out-of-pocket payments, while providing medicines to civil servants within the hospital because of the perception that the capitation rate for non–civil servants was inadequate (Mbau et al., 2020).

The findings that most healthcare service providers do not get adequate allocation per patient per day to cover for the management of most conditions agrees with Obadha et al., (2019) who found that capitation and fee- for- service payments from NHIF and private insurers were disbursed late and the capitation payment rates were perceived as inadequate. The expected fee- for- service payment amounts from NHIF and private insurers were predictable while capitation funds from NHIF were not because providers did not have information on the number of enrollees in their capitation pool. Capitation and fee- for- service payments from the NHIF and private insurers were reported as good revenue sources as they contributed to providers' overall income. Moreover, public providers had lost their autonomy to access and utilize capitation and fee- for- service payments from the NHIF.

According to Okungu and McIntyre (2019) that Kenya currently lacks evidence on whether income in the informal sector is sustainable and predictable and therefore able to support financing of universal health coverage (UHC). Key predictors of sustainable informal sector entities include monthly expenditure patterns, gender, marital status, household structure, number of employees in an entity, and land ownership in the rural area and number of entities owned. Informal sector entities are mostly unsustainable, meaning that the majority of premium contributors will not be consistent in payment and will likely to require subsidies.

IV. Conclusions

The study concludes that strategies on sustainable financial significantly influenced the achievement of UHC. However, it appears that there are still segments in the society especially the informal sector who are meant to be covered by UHC were not covered, hence, the sustainability of their financial capability and, hence, contribution to the scheme is still in question. This implied that creating sustainable financial mechanisms of healthcare while being instrumental to the achievement of UHC needed to be given more consideration in policy and strategy decisions especially with regard to models being adopted for the informal sector. There were indications that the government is strengthening and aligning PFM systems that determine how budgets are formulated, allocated and executed with health financing functions and health system objectives. However, the government was not efficiently directing and using funds ensure equitable access to quality health services and financial protection for all. Also, there were indications that not enough strategies have been put in place to raise revenues that can sustainably finance universal health coverage in Kenya as indicated by most of the respondents. However, spending targets have been put in place for the health sector to ensure sustainable financing. Further, most disagreed that with the view that health coverage schemes have increased access to health services for all citizens. The respondents, however, indicated that for the in insured individuals in the country, health coverage schemes assure availability of quality health services. The findings also suggest that monthly premium improves personal health seeking behavior among the citizens.

Therefore, the UHC policymakers and implementers need to consider a range of sustainable health financing schemes that have high penetration rates and low volatility. More consideration in policy and strategy decisions especially with regard to models being adopted should be given the vulnerable groups such as the informal sector for UHC to achieve higher coverage. Strategic health purchasing should also be adopted in the risk pooling models of financing.

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