


The Effects of Cost-Sharing On Healthcare Services Provision in Public Hospitals in Kenya: A Case Study of Kangundo District, Eastern Kenya

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ABSTRACT

Purpose: The focus of this study was to determine the effects of cost-sharing on healthcare services provision in public hospitals in Kenya by examining a case study of Kangundo District Hospital in the Eastern Provision of Kenya

Design/ Methodology/Approach: The study was conducted out in Kangundo District, Eastern Kenya which covers an area of 178.2 km: . Survey research design was used to collect data and was supplemented by field research (qualitative approach). 150 household heads were sampled to generate quantitative data while 10 health care providers from Kangundo District Hospital were interviewed as key informants. A standardized questionnaire was used to interview household heads in the three research sites. Multi-stage cluster sampling was used to select household heads while non-probability (purposive) sampling was used in the selection of the three locations and three sub-locations, respectively.

Findings: The study established that the introduction of cost sharing has not led to diverting demand of health care from public to private health care providers in Kangundo District, though patients still utilized private health care facilities in the district.

Contribution to policy and practice: There is need for Situational analysis on Health Insurance programs as a supplement to cost sharing in health care in order to strengthen the quality of policy decision making regarding access and equity in health care.

Originality/Value: This study is the first to empirically establish the Effects Of Cost-Sharing On Healthcare Services Provision In Public Hospitals In Kenya

BACKGROUND

Health sector reforms have been carried out in most countries in Sub-Saharan Africa for the more than two decades now. Indeed, the early 1990s was a decade of market reforms in healthcare not only in Africa but the world over. During this time, most European countries initiated market reforms aimed at expanding healthcare coverage at a lower cost. Quaye (2004: 95) notes that "the UK chose to expand consumer choice and reduce supply-side inefficiencies." The idea was to separate the purchaser from the provider of hospital and community health services, as well as the creation of general practitioners and the formation of hospital trusts in order to create competition. There were also the Dekker and Blum reforms in Netherlands and Germany respectively which focused on the introduction of market-oriented systems in the delivery of healthcare (Quaye 2001, 2004). In the 1980's and 1990's, African governments adopted the Western healthcare service delivery system which was started way back before independence in the 1950's and 1960's- a model whose emphasis is on hospital based and curative care.

Cost-sharing in Kenya's health sector is a policy initiative where the patient and the government or other healthcare providers share the cost incurred in the provision of health services. This is contrasted to the situation after Kenya's independence (1963). Whereby the government provided free health care to her citizens. On a populist stand, the government came generously after independence and promised free medical care. According to Collins et al. (1996:113), after independence in 1963, "the Kenyan government committed itself to providing universal access to medical services." This was intended to improve the health status of her citizens. In 1964, a pre-independence fee of KSh 5 per attendance was abolished while nominal in-patient and selected outpatient charges were retained. In 1989, however, the National Development Plan (1989-'93) advocated for expanded user fees in health, which was announced in October 1989. In December 1989, expanded user fees were introduced as cost-sharing. The new fees were introduced at Kenvatta National Hospital, the then 80 provincial and district hospitals, and the 320 health centres with health care services in dispensaries remaining free (Quick and Musau 1994).

According to the Ministry of Health (2002:11), the cost-sharing operations are such that the revenue generated from user charges and insurance claims (e.g., from National Hospital Insurance Fund) were to be deposited in the Health-care Service Fund, commonly known as Facility Improvement Fund (FIF). These revenues were retained separately by the Hospital Management Boards to supplement the budget allocations from the Treasury. Hospitals were allowed to use 75% of the revenue collected while 25% is for preventive/promotive activities in the district in which the funds are collected (KIPPRRA. 2004). The cost sharing revenue was to be used to improve the quality of health services in the facilities and to support district level and preventive health care (P/HC) services. These funds are managed by management boards. After collection at the facility level, the funds are banked in an account managed jointly by the District Health Management Boards (DHMBs) and the District Accountant. For health care facilities to access the funds, the Hospital Management Team has to present their budgets which are approved by the DHMBs.

Available literature indicates that even with the generation of revenue the expected gains in quality of health care have not been achieved fully (Shauri 1999:136; Kimalu 2001:17 and Mbatia 1996:219). Shauri shows that "quality of public health care has not improved", even with the formation of District Health Management Boards (DHMBs). In addition, the study revealed that in Kilifi and Taita Taveta districts, health facilities faced problems of lack of drugs

and other essential medical supplies. Mbatia observed that “despite the introduction of user fees, public health facilities in Murang’a (and in Kenya) still remained inefficient and unreliable.” He goes further to state that the quality of their services remained poor. This therefore means that the main objective of the cost-sharing programme, which was to encourage increased cost recovery and improve the quality of health care services from users of public health facilities, has not been met so far since its inception in 1989. This study therefore intended to establish why, despite revenue generation, the implementation of cost sharing has not matched the provision of quality health care by public health care facilities. This was done by establishing the relationship between generation of revenue and its management in provision of quality health care.

Research Problem

cost-sharing within Kenya’s health sector was meant to reduce government spending on provision of health as well as ensuring that public health became self-sustaining. Outside the public sector, other groups like church and non-governmental organizations have supplemented the government's efforts in provision of healthcare. However, it has been observed that most public health institutions have not developed any additional facilities and infrastructure even after the introduction of the cost-sharing. This might raise consideration regarding training in management skills for medical staff and administrators concerning collection and management of revenue generated through user fees. This relates to problems of management of both the process of revenue generation and utilization in order to meet the objective of provision of quality health care. In an effort to achieve quality health care, health care facilities need to be rehabilitated so as to offer quality services and meet extra demand. There is also need for development of quality standards for medical equipment and strengthening of the capacities of public health institutions to carry out promotive health care. Even though Kenya had to pursue adjustment policies due to the poor performance of the economy and donor pressure, the effects have been reduction in per capita expenditure on health and increase in user fees and in their enforcement. According to Lopez (1998:1) these factors “have contributed to deterioration in health status and a decline in health utilization among the poorer socioeconomic groups.” The researcher therefore attempted to establish how cost-sharing has affected potentiality of public hospitals in provision of quality health care to the public. In this regard, the study is guided by the following

Research questions.

- 1) Has cost sharing led to a diverting demand of health care from public to private Health care providers in Kangundo District?
- 2) What aspects on ability to pay by patients affect revenue generation by health care Facilities in Kangundo?
- 3) How has user fee charging affected household access to health care services from Public health care facilities in Kangundo?

Study Objectives

The general aim of this study was to establish the nature and impacts of cost-sharing on the provision of healthcare in public health institutions in Kangundo District.

LITERATURE

The development of Kenya’s health system

Kenya's current health care system is as a result of policies made more than four decades ago. However, the development of the healthcare system in Kenya can be traced to the precolonial era. The history of modern health services and policies in Kenya dates back to the establishment of the religious mission in the 1890's and the arrival of the imperial British East of Africa company (IBEA) in 1888. It was not until 1901, when a proper health care system was initiated in colonial Kenya. A medical department was created as one of the civil developments of the National administration (Owino and Okach, 2000). This became the first colonial medical organization supported and controlled by the State. The colonial health system established then, however, was to preserve the health of the European while ensuring that the African and Asian labour force was in good working condition. The organization was also charged with the responsibility of preventing the spread of tropical diseases.

Health Sector Reforms in Kenya

Health Financing in Kenya

This part gives an overview on who pays for health care services of patients in Kenya. As the researcher has already stated on attaining independence in 1963 the government of Kenya committed itself to providing free health care services as part of its development strategy to alleviate poverty and improve the welfare and productivity of the nation (Ministry of Health, 2003). However, in the 1980s, the government was unable to provide unlimited free healthcare (Oyaya and Raficin 2003 et al 1996). The major problem for the health sector was lack of adequate resources and this had a great impact on the financing for health due to "significant high demands for health service as well as constraints on the resources available from all sources (MOH 2003:3). Additionally, the emergence of complex diseases and increasing populations as well as economic pressures and subsequent implementation of Structural Adjustment Programmes (SAPs) and donor fatigue, meant that the government could not wholly finance the provision of health care to her citizens (Oyaya and Rifkins, 2003: MOH, 2003).

Performance of the cost-sharing programme

Differing views on the performance of cost-sharing emerge in the reviewed literature. Two camps were identified, the first (Mwabu-1987 and Collins et al.-1996) advancing the view that cost-sharing has met its objectives. The second, (Shauri-1999, Mbatia-1996, and Odada and Odhiambo-1989, Quaye-2004, and Lopez -1998) highlight divergent problems, which have led to the poor performance of cost sharing. In this study, it was therefore important to establish the potentiality of patients in paying for health care services as well as the potentiality to generate revenue by public health care facilities in Kangundo District

The social context of health and illness

Since health seeking behavior of patients was definitely affected by charging of user fees, it was important to examine the theories about health and illness. This would give an insight into "the ideas people use to explain how to maintain a healthy state and how they become ill" (Murdock. 1980:37). Murdock points out that ideas about illness causation include such ideas as breach of taboo, soul loss, germs, upset in the hot-cold balance of the body, or a weakening of a body's immune system. Consequently, theories of illness causation derive from the underlying cognitive orientation of a cultural group, and therapeutic practice usually follows the same cultural practice. A typology of theories of illness exists based on criteria derived in past from modern medical science and in part from anthropological experience. When trying to

explain health and illness, a basic dichotomy emerges between theories of natural causation and theories of supernatural (personalistic) causation (Murdock, 1980). Naturalistic theories of disease causation tend to view health as a state of harmony between a human being and his or her environment; when this balance is upset, illness will result. Biomedicine (modern traditional medicine) is founded on a naturalistic set of theories about the body. One of the core theories of contemporary biomedicine, is the germ theory of disease. A core assumption of the value system of biomedicine is that diagnosis and treatment should be based on scientific data. On the other hand, personalistic theories explain health and illness from the point of view of societal norms. If someone has violated a social norm or breached a religious taboo, he or she may invoke the wrath of a deity, and sickness— as a form of divine punishment— may result.

MATERIALS AND METHODS

The survey research design was used to collect data and was supplemented by field research. The study was an ex-post fact design. It entailed the examination of the effects of cost-sharing in health fifteen years after its implementation in Kenya. This was done by collecting data through survey research. More data were also collected using qualitative research methods to supplement quantitative data. The study was carried out in Kangundo District, Eastern Kenya. Kangundo District is on the northeastern side of Machakos District and covers an area of 178.2 km². It has a population of 91,238 with 44,420 males and 46,818 females and a population density of 512 people per km² and 18,065 households.

RESULTS

Regression Co-efficient

Table 1 Regression Results

	B	Std. Error	t	Sig.
(Constant)	1.752	0.234	7.470	0.000
Age	-0.2560	0.76	-3.227	0.001
Education	-0.049	0.082	-0.048	0.550
employment	0.238	-.102	.229	0.021
earning	-.057	-.097	-.584	0.560
Family size	0.009	-.044	.203	.840

$$Y = a + b_1X_1 + b_2X_2 + b_3X_3 + b_4X_4 + b_5X_5$$

Where X₁= Age. X₂= Education Level, X₃=Employment Status. X₄ = Earnings and X₅= Family Size.

From table 1 above all utilization of health care is inversely related to age. Increasing age by 1 unit decreases utilization by 0.27. This means that the higher the patient's age, the less the utilization of health care services from public health care facilities in Kangundo District. This finding was not strange since it would be expected that as one's age increases, visits to hospitals become less compared to when one is young. For instance, children under five would visit hospitals more frequently than, compared to say, one at the age of 25.

The fact that utilization of public hospitals in Kangundo is more by young children does not necessarily mean that older people neglect their health. The most plausible explanation would be

that older people might opt for self-medication through over-the-counter drugs from private chemists. Another reason for this is that children, especially under-fives, would make more visits to hospitals compared to older people due to the mandatory postnatal care like vaccination for Diphtheria, Tetanus, and Whooping Cough, and Bacillus Calmette-Gurin (BCG vaccine). From the regression model, it can also be observed that utilization of health care is directly related to employment. If employment is increased by 1 unit, utilization of health care services increases by 0.23. In other words, being employed means utilization of health care is more than being unemployed.

CONCLUSION

From the study findings, it emerged that patients in Kangundo District utilized public health care facilities more than private ones. This means that public hospitals were popular compared to private ones though this should not be used to mean that the services were better than in private ones. This therefore means that the introduction of cost sharing has not led to diverting demand of health care from public to private health care providers in Kangundo District, though patients still utilized private health care facilities in the district. Though data generated indicates that public institutions were popular, it is not an indicator that patients in Kangundo District had purchasing power of health care services. The study established that the patients preferred public health care facilities since the charges were comparatively cheaper. Ability to pay for health care services determines revenue generation. The data generated indicated that 92% of respondents in Kangundo were not in reliable employment and therefore this affected revenue generation.

Areas for Further Research and recommendations

From the summary of the research findings, the researcher made the following recommendations.

The hospital management committee should ensure that the revenue generated is fully utilized to ensure that public health care facilities can provide quality health so as to ensure that there was no diversion of demand for health care. The public hospital should provide safety nets to ensure that patients who are unable to pay for health care are catered for. This means providing more waivers and exemptions to poor patients. In addition, the government needs to provide means to cushion the residents of Kangundo from poverty so as to give them the purchasing power. There is need for more health care facilities to ensure even access of health care services by patients. Government budgetary allocations should cater for health care infrastructure in the district.

Further research is important in order to provide insights in such areas as:

Situational analysis on Health Insurance programs as a supplement to cost sharing in health care in order to strengthen the quality of policy decision making regarding access and equity in health care. Factors that influence health-seeking decisions at the household level, e.g., income, household structure, facility-specific variables and other competing needs for scarce household resources. At the household level, we are yet to establish the extent to which families are being impoverished by selling assets and/or borrowing to obtain health care.

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