THE CHALLENGE OF COMPETITION AND COMPETITIVE STRATEGIES USED BY PUBLIC HEALTH INSTITUTIONS IN KENYA

By

BANDA MARGARET ATIENO

A Management Research Project Submitted in Partial Fulfillment of the Requirements for the Award of the Degree of Masters of Business Administration of the University of Nairobi

October, 2006

DECLARATION

I hereby declare that this project is my original work and has not been submitted either in the same or in different form to this, or any other University or Institution for a degree

UNIVERSITY OF NAIROBI
SCHOOL OF BUSINESS
MBA OFFICE
P. O. Box 30197
NAIROBI

.....
Signed

26/10/2006
.....
Date

Margaret A. Banda
D61/P/8188/02

This project has been submitted for examination with my approval as the supervisor

.....
Supervisor

26/10/2006
.....
Date

Dr. Martin Ogutu
Lecturer
Department of Business Administration
School of Business
University of Nairobi

DEDICATION

This research work is dedicated:

To my mother: **Mrs Agnes Adhiambo Banda**

Who has always encouraged

And

Taught me the value of education

ACKNOWLEDGEMENT

A number of people have contributed either directly or indirectly towards the completion of this research. I wish to sincerely thank all of them.

My appreciation goes to my family for the continued support and patience during the entire MBA programme. I particularly thank **Dr. James Ger** for his encouragement and support throughout this programme. May the Almighty Father bless you and give you the desires of your heart. I am also indebted to **Norah, David, Michael and Carol** for their patience throughout this programme.

Above all, special thanks go to **Dr. Martin Ogutu** who has supervised and guided me throughout this research project. He was always available for consultation and gave me valuable guidance and direction. The constructive criticism and countless hours spent on this research project are highly appreciated. I am also indebted to **Dr. Jack Nyamongo** who supported and recommended me to the Ministry of Health to be allowed to enrol for this course. I would also like to appreciate the great support from **National Aids/STI Control Programme (NASCOP)** for reimbursing part of my school fees which went along way in seeing me complete this programme.

I would also like to appreciate my **MBA colleagues** for the spirit of high performance and hard work that we helped develop during our discussions, in and out of class. I thank you all for your generous support and cooperation that helped make all the difficult issues clear and simple.

For all those that I am indebted to but have not mentioned here, I greatly appreciate all their contributions.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Figure

ABBREVIATIONS

AAR	African Air Relief Services
CHAK	Catholic Health Association of Kenya
KHPF	Kenya Health Sector Strategic Plan
KNH	Kenyatta National Hospital
MOH	Ministry of Health
NGOs	Non Governmental Organisations
NHSSP	National Health Sector Strategic Plan
NSHIF	National Social Hospital Insurance Fund
R&D	Research and Development

ABSTRACT

The essence of formulating competitive strategy is to relate a company to its business environment and enable it to cope with competition. Competitive strategy is therefore the bases on which an organisation or a business unit might achieve an advantage in its market.

This study focused on the challenges of competition in the health sector industry with emphasis on how the public health institutions are responding to these challenges in order to meet their goal of providing accessible, affordable quality health care services to its people. Previous scholars have concentrated on public health institutions and its health care financing but have overlooked the issue of competition and how the Public health hospitals are presently surviving to offer quality and affordable health services to their patients in the face of this competition.

This study was designed to fill the gap by focusing on competition and how public health hospitals survive this competition to achieve their goals. The study sought to answer the following research questions: 1) what challenges do public health hospitals face from the private health sector, 2) Which competitive strategies have the public health hospitals adapted to counteract the private hospitals?

This study was conducted between October, 2005 and April, 2006. The design of this study is a sample survey of public health hospitals in Kenya. The population of interest therefore includes all public health hospitals in Kenya.

The sampling design (frame) included 1 national referral hospital, 2 provincial hospitals, 5 district hospitals and 4 health centres. This gives a total of 12 health institutions.

Data was collected using a semi-structured questionnaire comprising of 18 both open-ended and close-ended questions. Primary data was collected using an interview guide.

The questionnaire was divided into three parts. Part A comprised general information; part B was comprised of questions that determines challenges from the environment and part C were questions on the strategies used by the public health hospitals to response to these challenges. Challenges were found to exist in the environment especially those from the private hospitals. It was also found that the public health hospitals deployed strategies to counteract these challenges. Both these were confirmed by mean scores of three and above and percentages of fifty and above.

CHAPTER 1: INTRODUCTION

1.1 Background

The essence of formulating competitive strategies is to relate a company to its environment and enable it cope with competition. Competitive strategy is the basis on which firms protect themselves from business attacks or offences from other firms in the same industry.

Porter (1998) describes competitive strategy as taking offensive or defensive actions to create a defendable position in an industry, to cope successfully with the five competitive forces and thereby yield a superior return on investment for the firm. Firms have discovered many different approaches to this end, and the best strategy for a given firm is ultimately a unique construction reflecting its particular circumstances.

Competitive Strategy is the bases on which a business unit might achieve competitive advantage in its market. For public service organizations, the concern is with an equivalent issue: the bases on which the organization chooses to sustain the quality of its services within agreed budgets; how it provides 'best value' (Johnson & Scholes, 2003).

Hax and Majluf (1996) views this concept as the positioning of the organization in its environment, responding to external opportunities and threats, and internal strengths and weaknesses in order to achieve a sustainable advantage over the key competitors of the firm in every business in which it participates.

1.11 Competition and Competitive Strategies

Competition in an industry is rooted in its underlying economic structure and goes beyond the behavior of current competitors. The nature and degree of competition in an industry depends on competitive forces from its environment. The state of competition in an industry depends on the collective strength of these forces. The collective strengths of these forces ultimately determines the attractiveness or the profit potential of the industry, where profit potential is measured in terms of long run return on invested capital.

The key structural features of industries therefore determines the strengths of competitive forces and hence industry profitability. Whatever their collective strength, the organizations goal is to find a position in the industry where it can best defend itself against these forces or can influence them in its favor (Porter M, 1998). To cope with them, the strategist must analyze the sources of competition to find out what makes the industry vulnerable to those forces. Knowledge of these underlying sources of competitive pressure provides the groundwork for a strategic agenda of action.

Porter's framework popularly known as the five-force model is one approach to understanding industry competition. Economists, other scholar's and laymen too have different models for industry competition. Porter's model is the most popular and most relevant for open market economies. Porter discusses five forces that determine the nature of competition in an industry, namely; the threat of new entrants, the bargaining power of customers, the bargaining power of suppliers, the threat of substitute products or services (where applicable), and rivalry among current contestants.

Competition in an industry continually works to drive down the rate of return on invested capital toward the competitive floor rate of return or the return that would be earned by the economist's "perfectly competitive" industry. Investors will not tolerate returns below this rate in the long run because of their alternative of investing in other industries, and firms habitually earning less than this return will eventually go out of

business. The presence of rates of returns higher than the adjusted free market return serves to stimulate the in-flow of capital into the industry either through new entry or through additional investment by existing competitors.

From the above descriptions and explanations of competition and competitive strategies it can therefore be concluded that organizations operate within external environment, which make them to be environment serving or dependent. The many forces at work in the industry environment are potentially important in developing business strategy.

Prior to independence access to modern health services was limited and patients had to pay fees, although very small amounts were involved. Since independence the government of Kenya made free health services to its users in the public health institutions. This policy was widely accepted and supported as most Kenyans grew to believe that the government was responsible for meeting their needs. However, following the economic problems of 1980s, increasingly stringent budgets, growing population and expanding demand for health services, taxed resources the government needed just to maintain the existing public health systems and services.

Lack of resources meant that the public hospitals could not offer quality services. This made the government to start a series of the health sector reforms to meet the challenge by seeking more efficient service delivery, better quality of care and greater coverage. It should be noted that the healthcare reforms formed part of the wider reforms that were being undertaken by the Kenya Government. These are spelt out in the policy framework paper of 1996, entitled Kenya's Economic Reforms for 1996-1998. Other reforms complementing the sectoral reforms include the Civil Service Reform/Rationalization Program and reforms of key sectoral ministries. However, some of the health sector reforms such as Cost Sharing have been by no means universal since there still remains a strong belief in the philosophy of free health care.

Pricing of health services as much as it increased the level of resources available to the facilities posed a challenge to the policy experts and decision makers. It meant

that patients who were able could turn to private sector while their contributions were needed in the public hospitals to subsidize the financially vulnerable patients and to provide quality health services to those who needed it. This also encouraged more health providers to open up health facilities which led to more competition for patients over resources. The flow of qualified health professionals away from the Ministry of Health towards the private sector is also an indication of competition.

The above background and review indicates that public hospitals are faced with competition in the present environment and they have to survive in order to offer health care services to all those who need it without excluding the poor. Survival is therefore critical as some of the public hospitals that cannot survive the competition have closed down. For instance few dispensaries and health-centers in the country plus those that have failed to open up due to lack of resources. Therefore competition should not be taken for granted.

This study therefore seeks to analyze the current situation of the health sector, outlining the challenges of competition, and the competitive strategies it should deploy against competition in order to offer quality healthcare services to patients who are in need. The study is based on studies and reports prepared on the health sector and on the experiences of stakeholders.

1.1.2 Public Health Institutions in Kenya

The Ministry of Health is vested with the overall mandate for health services promotion under the Public Health Act Cap 242 of the Laws of Kenya and under various subsidiary legislations dealing with the specific areas of health services provision. It is therefore responsible for the creation of an enabling environment for the provision of sustainable quality health care that is affordable and accessible to all Kenyans. The health sector comprises of the public health system with major players being the Ministry of Health and the Ministry of Local Authority. Other players are the NGOs, missions and the private sector. Health services are delivered through a network of about 4200 health facilities with the public health system accounting for 51% of the total.

Kenya's public health infrastructure has grown rapidly since independence and presently the Ministry of Health has built an impressive pyramidal health referral system. (This was made possible with considerable support from harambee efforts). At the apex are Kenyatta National Hospital (KNH) and Moi Referral Hospital which are the national referral hospitals. Below KNH are 7 provincial hospital; 69 districts and sub-district hospitals; 329 health centers and about 1,100 dispensaries. The dispensaries provide basic consultation services and drugs. Health centers generally have a pharmacy and a laboratory as well as a few beds for delivery or transit. The sub-districts range from a little more than health centers to large district type facilities. Presently all provincial and district hospitals have separate private wings known as Amenity Wards. The MOH management structure is therefore in four levels: central, provincial, district and facility. KNH operates as a state corporation under the MOH (Collins et al. 1995). Despite these major gains, population growth outstrips the capacity of the Ministry of Health to cater for the demands of services.

The Government remains the major financier of health care services, meeting nearly half of the national health recurrent expenditure (Ministry of Health 42 per cent and Ministry of Local Authority 5 per cent). The private market (insurance and out of pocket modes) meets 42%, while the missions, donors and NGOs meet 7% (NHSSP: 1999-2004, 1999.) of the expenditure.

The MOH has the lowest percentage of total expenditure in spite of the workload, the number of facilities and manpower attributed to it, compared to all other health providers (see table 1.below). However, this is not reflected in its infrastructure or manpower. This therefore explains the tendency for private and the mission sector institutions to pay staff significantly higher salaries than the Ministry of Health. The Ministry of Health institutions are overstaffed in comparison with non-governmental institutions and staff members are poorly paid. This has in the past seen a large flow of qualified health professionals away from the Ministry of Health towards the private sector.

The Kenya Health Care Policy Framework states that there is a general lack of the essential inputs required for effective patient care in pubic hospitals. None of these augers well for providing quality health care in MOH facilities and with the existence of these structural imbalances, it is not surprising that the Ministry is increasingly unable to provide adequate levels of quality care in its institutions.

Lack of resources has given rise to the need for extra revenue which has seen the introduction of cost sharing. Since the fee for poor patients have to be paid, this burden therefore falls on the government because the private schemes do not accommodate these who can not afford and the poor. This has given rise to competition for resources over patients.

1.1.3 Other health care providers

Other players in the delivery of health services are NGO, mission and the private sector. They account for 49% of the total health facilities within the health sector i.e. the private form 29% while the mission and NGO 20% (National Health Sector Strategic Plan). Diagram

NGOs and the private sector provide both curative and preventive health care services. The NGOs and private provider and household provide about 47% of funds flowing to the health sector. NGOs receive substantial support from donor- directly – and from the government – mainly through medical personnel. Household mainly contribute to health care financing through payment of fees and over the counter purchase of drugs (NHSSP pg. 33)

Private for-profit services have grown over the years but have mainly focused on better-off urban patients. In the early 1990 there were about 840 0f these facilities (M.O.H 1994b). However by late 1990s there were about 1220 of these facilities of which 42 were hospitals and the rest were mostly dispensaries, clinics and nursing and maternity homes.

Private non-profit services are provided through about 600 facilities of which 63 are hospitals and most of them belong to religious missions. Reductions in support from government and donors plus the inability of patients to cover a higher portion of costs has meant that many non-profit providers have been struggling to survive. The financial situation of these non-profit providers is of great concern, since they have traditionally provided a great amount of free or subsidized preventive services, and free services to the poor, with much of their coverage in the rural areas. With the for-profit providers' focus on better-off patients and the financial difficulties of non-profit providers, the burden of trying to meet the increasing demand, especially from the poor, has fallen on the government (Collins et al 1996).

As a result of the above reductions in support, there exist trends indicating a decline in the quality and quantity of care offered by mission facilities. This is matched by an increase in the numbers of private health facilities with a pronounced urban bias.

The assumption that, in Kenya the private sector is in general more cost-efficient than the public sector may not be true. A recent study carried out in Kenya on costs and quality of care provided in mission, for-profit and government hospitals suggest that for-profit hospitals (purely private) provide comparable quality health care to mission hospitals but at a very high cost. Also, many Government facilities may be providing care at higher than optimum cost and lower than optimum quality. However, considerable cost savings may be possible through improvements to management practices without compromising the quality of care delivered (Kenya's Health Policy Framework 1994).

There is a tendency for private and mission sector institutions to pay staff significantly higher salaries than the Ministry of Health. This is despite the fact that the Ministry of Health has the lowest percentage of total expenditure in relation to private and other health care providers. This further means that the Ministry of Health institutions are over staffed in comparison with non-government institutions and staff members are poorly paid (Kenya Health Policy Framework pg. 19)

1.2 Statement of the Research Problem

The policy to introduce free health care was widely accepted and supported and it made people to believe that the government was responsible for meeting their health needs. However, the economic problems of 1980s contributed to the need to pay for health services in the public health facilities. This posed a challenge to the decision and policy makers as it meant that services could no longer be free. The introduction of Cost Sharing made it possible for patients who could afford to choose where to get their services. This encouraged more private health providers to join the sector to provide quality health services

The plight of the poor and those who could not afford health services were at stake and therefore their burden fell on the government as the caretaker of its people. In order to provide health services to all who need it, the public health institutions have to compete with the private and other health institutions over patients. This then gives rise to competition for patients who can afford in order to provide resources for the poor who form the larger percentage of patients. The inclination of the private health institutions to focus on those who can afford and leave out the poor has further contributed to this problem.

If the government could be able to provide quality healthcare services free of charge to all those who needed it then there could be no competition. However, lack of adequate finance and resources contributes to the need of extra funds to cater for all those who need healthcare services. Competition in this industry is for patients over resources.

From the above statements and arguments the problem is therefore how public health institutions can survive competition in order to give quality health care to all those who need it. It is therefore important to consider and understand what public hospitals consider as challenges from the other health care institutions, as far as the provision of quality healthcare services to all and the poor are concerned. It is further important to consider the strategies that the public health institutions use to fight competition. This therefore leads us to the following research questions:

I) What challenges do public hospitals face from the private health sector?

II) Which competitive strategies have the public health institutions adapted to counter-act the private health institutions?

Scholars have written much about public hospitals and its health care financing but none has studied the competition that exists between the public and the private hospitals on the same issue. The issue of competition has been assumed and rather overlooked by them. As can be seen no study has focused on competition on how public health institutions compete in order to survive. This therefore contributes to the reason why "competition" is an issue which should be studied.

1.3 Research Objectives

The objectives of the study are:

1) To determine what public hospitals consider as challenges from the private hospitals.

2) To determine the competitive strategies adopted by public hospitals to counter-act competition by the private hospitals.

1.4 Importance of the Study

This study will enable the policy makers and decision experts (Government) to come up with better policies and decisions that provide an enabling environment for the provision of improved healthcare services.

It will enable the Ministry of Health to see clearly the competition that does exist and therefore stimulate the Government to come up with competitive strategies that will enable it to mobilize enough resources for sustainability and give wider coverage of service to all those who need it. It should also encourage the public health institutions to enhance the existing strategies.

It should further stimulate competition amongst the wider panoply of providers of healthcare in both the Government and private and mission sectors to provide quality healthcare and further realize that quality of services at subsidized costs is partly what matters to the patients especially if they have to pay for services, hence they should further learn from each other.

It should make private and other providers understand that the provision of quality healthcare services to all who need it is the responsibility of all health providers and not just the Government.

It will enable the public health providers to come up with efficiency improvements that will provide more services for the same amount of resources or use fewer resources to provide a constant level of services, which may lead to equity improvements. If fees are high enough to cover the cost of services and provide a small cross-subsidy, the fees will still be lower than private-sector fees, and they will generate funds to cover the cost of services for patients who cannot afford to pay. Both patients who can pay and cannot will benefit.

1.5 Organization of the Final Report

The research report constitutes five factors. Chapter 1 is introduction covering the background, statement of the research problem, research question, objectives and the importance of the study. Chapter two is literature review and constitutes an analysis of the environment and competition, challenges of competition and competitive strategies of public health institutions against competition from the private health sector. Chapter three is the research methodology which defines the research design, population, sampling design, data collection procedures, data description and conversion and methods of analysis used in the research. Chapter four covers data analysis and findings. Chapter five is comprised of conclusions, recommendations, limitations and suggestions for further research in this area.

CHAPTER 2: LITERATURE REVIEW

2.1 Environment and Competition

Environment refers to causes or factors external to an organization that affects the organization's operations. The organization has little control if any over such factors. The forces affect the organization by posing opportunities and threats to the organization as it endeavors to achieve its objectives. Opportunities enhance or favor achievement of objectives. An opportunity for an organization could be a threat for another depending on the capability of the organization. Therefore the relevant environment is very broad. However, the key aspect of the firm's environment is the industry or industries in which it competes. The external environment is dynamic as it continuously causes new challenges in terms of opportunities and threats. Due to its uncontrollability, firms need to adjust to changes by adapting to them in order to succeed. Consequently, industry structure has a strong influence in determining the competitive rules of the game as well as the strategies potentially available to the firm (Pearce,J.A and Robinson, R.B,1997).

The health sector industry is dynamic presently comprising of many health providers (players) with the major one being the Ministry of Health. The other players are the private health institutions, NGOs and mission. This has made the level of competition in this sector to be quite high. The basis of competition in this industry is for the provision of quality services at affordable costs. Rivalry among the existing competitors is related to the presence of a number of numerous competitors especially from the private sector. Some of these competitors are roughly equal in size. Rivalry is quite stiff and is manifested by homogeneity of products among others. Since the products and services in this industry are basically similar and lack differentiation, the buyers (patients) can therefore play one health facility against another as they are sure to find alternative suppliers. Most of the competitors have therefore maintained their market share because of the quality of their services and also due to customer loyalty. In spite of the underperforming economy, the profitability of the industry is quite attractive therefore making it a target for those firms' private firms that would like to exploit its potential. The Government policy to create an

enabling environment for other health providers meant for their expansion to take on incremental services over and above those which the Government undertakes made the industry a source of easy entry.

2.2 Challenges of Competition

In the study of the fall and rise of Cost Sharing (Collins et al 1996), it is shown that health care has been free in Kenya since independence and great strides have been made to improve the services. However, the demand for health care resulting from rapid population growth, the advent of HIV/AIDS, and the resurgence of other diseases have overstretched the public health services. Therefore, as the economy continues to struggle from the above calamities the life of the ordinary Kenyan has become harder and the challenge of providing health care to all has continued to increase as explained by the following literature review.

Newbrander and collegues (2001) have shown that the demand for health services also depends on the perceived quality of the services. If quality of services does not improve, it is likely that demand will fall, particularly when there are alternative sources of care. The public perception has been that private hospitals provide better quality health care services than public hospitals. If patients perceive an improved quality of care, the fall in demand may be reduced or eliminated. For example, improved drug supply as part of a user fee scheme in some countries has resulted in increased use of services. In Kenya quality has been a major reason for both the poor and the rich seeking care at the hospitals that charged user fees. To encourage local public support for user fee, funds have been used for quality enhancements that are obvious to the patients such as improved supply of drugs or bed linen and other basic ward supplies. This is because patients including the poor accept fee when they relate to services that are clearly of a high quality. Medical supplies play an important role in enhancing the quality of health care delivery Research findings have shown that the use of public health facilities is directly related to the availability of drugs and other medical supplies (National Health Sector Strategic Plan Pg. 34).

The private health institutions have the resources to provide quality health services

and therefore attract patients who can afford. However, the public health institutions are faced with scarcity of resources and the financially vulnerable patient who form the majority number of patients. Presently currency devaluation and inflation have constrained the ability of the Ministry of Health to provide its facilities with adequate drug supplies. A large share of Ministry of health drugs and dressings supplies are provided for in the development budget by contributions from international donors. This calls for the Government to address the question of the future sustainability of the supplies. Despite rising prices there are no shortages of drugs and dressings in private sector pharmacies. However, the prices of medicine in these retail outlets are beyond the reach of most Kenyans. This places a heavy burden upon vulnerable groups and the solution to these problems presents a serious challenge to the Ministry of health (Kenya Health Policy Framework).

In the study of the 'user fee' systems (Newbrander et al 2001) it was found that financial incapability is one of the major critical problems which constrain the ability of the Ministry of Health, to legislate for and ensure the delivery of adequate levels of quality health care in Kenya. The Ministry of health is seriously under funded as per capita expenditures have greatly dropped since 1980/81 from US $9.50 to US $3.50. The share of recurrent budget allocated to the Ministry of Health has also declined since 1979/80 compounded with the continuous devaluation of the Kenya shilling. Private institutions unlike the public institutions are financially capable and can therefore target the better-of patients and harvest the bigger percentage of profit. This therefore makes the private for-profit institutions have the financial resources to provide quality services to those who can afford who form the minority group but produce the larger amount of facility fund. The financially vulnerable form the majority group that cannot afford and is therefore the burden of the government. This kind of arrangement can perpetuate a vicious circle where the private continuously have the finance while the public does not have. However, since the fee for the poor have to be paid for, the public health institutions compete over patients who can afford in order to provide quality health services to all who need it.

Price of health services (fee level). Traditionally price has operated as the major

determinant of buyer choice and this is still the case in poor nations (Newbrander et al, 2001). Introduction of Cost Sharing meant that the Government had priced health services in the public health facilities. Pricing of health services is synonymous with the private health sector which therefore gives them an upper hand in competition. Competition further meant that patients could make choices of either attending private or public health sector. Those who were able could turn to private sector while their contributions were needed in the public hospitals to subsidize services for those who could not afford and also provide them with quality health services. Patients had come to accept the legacy of paying for services only in private hospitals. Cost sharing reform represents a significant policy change for many countries. It has been by no means universal since there still remains a strong belief in the in the philosophy of free health care. Even in countries that have adopted user fees, social solidarity and the belief that health care is a basic right continue to support a widespread view that access to health services should be based on need, not on the ability to pay (Newbrander et al).

Pricing of health services (cost sharing) has further encouraged rivalry and stiff competition against the public hospitals. In May 2005, the president stated that the government could not provide free health care under the National Social Hospital Insurance Fund (NSHIF). This was a slap on the face for the poor. The result of the uncertainty surrounding the implementation of the health bill has seen private firms cashing in on the void to provide lower cost services while at the same time excluding the poor. The apparently crumbling public healthcare has seen the mushrooming of many private firms including those run by alternative medicine. Three years ago a consortium comprising of the AAR Health Services, AAR Credit and K-Rep Development Agency started a health financing project (Afya Card) aimed at developing and testing a private sector-driven, affordable and commercially viable health financing scheme for low income groups that costs as low as sh6,000 per person per year. The group currently receives an average of one thousand (1000) patients' visits per clinic month (Sunday Nation of 5th June, 2005). Such groups target the low income group that can afford their services. However, those who cannot are burden of the Government.

Technology: Private hospitals have taken the lead in technology. They are well equipped with sophisticated diagnostic facilities. This means that the public hospitals have to refer all their patients who need these services to private health institutions. However, because of their high costs these facilities can only be afforded by a few people (the better-off). The Ministry of Health recognizes that many public health facilities are in need of rehabilitation and replacement of the basic capital equipment essential for the effective and efficient provision of quality health care. The expansion of the infrastructure has not been matched by a rise in maintenance revenue which has resulted in the physical deterioration of facilities and equipment. Further, the Ministry of Health has been unable to enforce standards for the type, quality and capability of the array of equipment, fixtures it requires. This has been due in part to pressure and bias imposed by development partners who supply most of these items. (National Health Sector Strategic Plan pages 22 & 39).

Human resource: Over the years most private hospitals have been able to motivate their staff than the public hospitals. Poorly paid and unmotivated staff has been one among the numerous signs of deterioration of government health services. In spite of the fact that over 70% of recurrent budget is being devoted to the payment of staff salaries and benefits, they are still demoralized due to poor package. As a result of poor salary packages numbers of professional staff are still leaving the service for greener pastures locally and abroad (Shipp 1991). The 'The Standard of 9th September, 2005' states that in the last three years five hundred (500) nurses have been sneaked out of the country to work in Europe and given better jobs.

Customer care: Staff still engage in part-time practice in private sector where they offer the best of their customer care. This is done while still in the employment of the government to the detriment of patients who come for medical attention in the government institutions. This has left the public health institutions with a negative image. A large part of the MOH recurrent budget is still consumed by staff costs, leaving little for supplies and service operating costs. Shortage of drugs and supplies still remain common and is still possible to find hospital staff idle while patients go

elsewhere for services (Ministry of Health, 1994a, 1994c, 1994d).

Management skills: The delivery of health services is dependent on the availability of sufficient resources. The World Health Organization states that one of the major results of world action is to ensure equitable access to health services should be the optimal management of financial, human and material resources. Private and other health providers have human resource with management skills that are market oriented. This has enabled them to accumulate enough resources and be able to attract professionals away from the Ministry of Health towards the private sector. Due to the flow of qualified health professionals from the public sector there is need to continuously develop management and planning capacity in human resource at provincial and district levels. The Ministry has traditionally favored centralized planning and resource allocation principally from independence. The centralized system has a number of operational problems constraining the delivery of efficient and effective health services. Considerable cost saving may be possible through improvements to management practices without compromising the quality of care delivered.

Locations: Most of the private for-profit health providers are located in the urban areas. The mission hospitals however located in the rural areas are currently financially unstable because of the dwindling support from the donors. It has been observed that 50% of CHAK hospitals are financially unstable, 40% are just surviving and occasionally breaking even while only 10% are doing well (Sustainability of Christian Health Institutions, 2003). This has made the Government policy to create an enabling environment for other health providers meant for their expansion to take on incremental services over and above those which the Government undertakes not feasible. Gallacchi (1998) states that it has made the attempt by the government to shift responsibility of health care to the private sector not a very viable option. This is because the purely private health institutions are perceived as driven by profit only. As a result they are not ready to operate in the rural areas where income is perceived to be low. Therefore the plight of the poor in the rural is the burden of the government and its public health institutions.

Market share: The private for-profit health providers tend to focus on the better-off patients (Collins et al, 2001). This means that although the better-off constitute a small market share, can afford the expensive services offered in these institutions and therefore contribute to the private sector the large amounts of funds. The larger market share left to the public health institutions normally contributes little amount of fund as services in the public health institutions are subsidized while a good number of patients cannot afford to pay for the subsidized services.

Laws governing the health sector have not been successfully enforced and in some cases amended to respond better to present circumstances. Many professional engage in part-time practice while in the employment of the government. These professionals give more time to their part-time private practice than to their employer often at the detriment of patients who come for medical attention in government health institutions.

Secondly, the absence of a nationwide inspectorate system for quality assurance on health care has resulted in unlicensed and unqualified health care providers and institutions countrywide. Further, the mushrooming of unregistered clinics run by staff not licensed under the existing laws has threatened the well-being of the general public. Most of these clinics mismanage patients who end up in the public hospitals with more complications and with no money to pay for their services. Therefore, private practice needs to be regulated for the public good. Lack of policy guidelines to regulate the use of alternative medicine and cosmetics has also emerged as an area of concern to stakeholders in health care (The Standard of 10th October, 2005. Cover Page 5).

2.3 Competitive Strategies

Generic market-facing options are based on the principle that organizations achieve competitive advantage by providing their customers with what they want, or need, better or more effectively than competitors, and in ways which their competitors find difficult to imitate. Assuming that the products or services of different businesses are

more or less equally available, customers may choose to purchase from one source rather than another because either (a) the price of the product or service is lower than a competitor's or (b) the product or service is perceived by the customer to provide better 'added value' or benefits than that available elsewhere (Johnson and Scholes, 2003). Important implications which represent the generic strategic options for achieving competitive advantage flow from these broad generalizations, for example, the 'Strategy Clock' and the 'Three Generic Strategies'.

According to Michael Porter (1998), at the broadest level three internally consistent generic strategies are identified for creating a defendable position in the long run and outperforming competitors in an industry. These strategies can be used singly or in combination. These strategies are:

i) Overall cost leadership.
ii) Differentiation
iii) Focus

To effectively implement any of these strategies require total commitment and supportive organizational structures.

Overall Cost Leadership

The objective of this strategy is to achieve overall cost leadership in an industry through a set of functional policies aimed at this basic objective. A great deal of managerial attention to cost control is necessary to achieve these aims. Cost leadership requires aggressive construction of efficient-scale facilities, vigorous pursuit of cost reductions from experience, tight cost and overall control, and cost minimization in areas like R&D, service, sales force, advertising etc. Low cost relative to competitors becomes the theme running through the entire strategy, though quality, service, and other areas cannot be ignored.

A low price strategy seeks to achieve a lower price than competitors whilst trying to maintain similar value of product or service to that offered by competitors (Johnson

and Scholes, 2003). For example, by the late 1970's and early 1980's, the improved quality and reliability of the Japanese car manufacturer's changed the perception of their cars to that of being as good as their European competitors. However, the Japanese cars continued to be sold at a cheaper price than their rivals, which allowed them to increase sales volume further. Blue Band margarine have competed with butter from the Kenya Creameries Corporation over the years and finally achieving a higher market share. This was achieved through the provision of quality and reliable products while selling at lower price. In the public sector, costs are in effect, the price of a service to government as the provider of funds.

A low-cost position protects the firm against all five competitive forces. It gives the firm a defense against rivalry from competitors, because its lower costs mean that it can still earn returns after its competitors have competed away their profits through rivalry. It defends the firm against powerful buyers because buyers can exert power only to drive down prices to the level of the next most efficient competitor; it provides a defense against powerful suppliers by providing more flexibility to cope with input cost increases. The factors that lead to a low-cost position usually also provide substantial entry barriers in terms of scale economies or cost advantages. Finally, a low-cost position usually places the firm in a favorable position vis-à-vis substitutes relative to its competitors in the industry.

Achieving a low overall cost position often requires a high relative market share or other advantages, such as favorable access to raw materials. It may require maintaining a wide line of related products to spread costs, and serving all major customer groups in order to build volume. Consequently, implementing the low-cost strategy may require heavy up-front capital investment in state-of- the art equipment, aggressive pricing, and start-up losses to build market share. High market share may in turn allow economies in purchasing which lower costs even further.

An organization that aims to achieve competitive strategy through a low price strategy can do it in two ways to achieve sustainability. (1) It should identify and focus on a market segment which is unattractive to competitors in order to avoid competitive

pressures that erode price below levels which would achieve acceptable returns, for example, mortuary services. (2) Where there is competition on the basis of price is a more challenging situation. This is a common occurrence in the public sector and for many firms with commodity-type products and services. Tactical advantage may be gained by reducing price; but it is likely to be followed by competitors, with the danger of a slide into margin reduction across an industry as a whole and inability to reinvest to develop the product or service for the long term, for example, the dairy industry in Kenya. A low price strategy can only be pursued with a low cost base. Low cost in itself is not a basis for advantage if competitors can also achieve the same low costs.

Differentiation

This generic strategy seeks to provide products or services unique or different from those of competitors in terms of dimensions widely valued by others. Porter states that differentiation strategy is one of differentiating the product or service of the firm, creating something that is perceived industry-wide as being unique. The aim is to achieve higher market share than competitors which could in turn yield cost benefits by offering better products or services at the same price; or enhanced margins by pricing slightly higher. Approaches to differentiating can take many forms: design or brand image (as seen in Mercedes automobiles) technology (Sony TVs'), features, customer services, dealer network, or other dimensions. Ideally the firm differentiates itself along several dimensions.

Differentiation if achieved is a viable strategy for earning above-average returns in an industry because it creates a defensible position for coping with the five competitive forces, although in a different way than cost-leadership. Differentiation provides insulation against competitive rivalry because of brand loyalty by customers and resulting lower sensitivity to price. It also increases margins which avoids the need for a low cost position. The resulting customer loyalty and the need for a competitor to overcome uniqueness provide entry barriers. Differentiation yields higher margins with which to deal with supplier power, and it clearly mitigates buyer power, since buyers lack comparable alternatives and are therefore less sensitive to price. Finally, the firm that has differentiated itself to achieve customer loyalty should be better

positioned vis-à-vis substitutes than its competitors.

Most often differentiation may not mean achieving high market share. More often achieving differentiation will imply a trade-off with cost position if the activities required in creating it are inherently costly, such as extensive research, product design, high quality materials, or intensive customer support.

A differentiation strategy seeks to provide products or services unique or different from those of competitors in terms of dimensions widely valued by buyers. The aim is to achieve higher market share than competitors by offering better products or services at the same price; or enhanced margins by pricing slightly higher. For example, by mid-1990 the Japanese searched for ways to differentiate their products by providing extra features such as air-bags, air-conditioning and long-term warranties. In the dairy industry, the makers of blue-band have differentiated their product by adding more nutrients and making it serve multi-purpose needs thus making it to be priced slightly higher than its competitors.

Focus

It focuses on a particular buyer group, segment of the product line or geographic market. The entire focus strategy rests on the premise that the firm is thus able to serve its narrow strategic target more effectively or efficiently than competitors who are competing more broadly. As a result, the firm achieves either differentiation from better meeting the needs of the particular target, or lower costs in servicing this target, or both. Even though the focus strategy does not achieve low cost or differentiation from the perspective of the market as a whole, it does achieve one or both of these positions vis-à-vis its narrow market target.

The firm achieving focus may also potentially earn above average returns for its industry. Its focus either means that the firm either has a low cost position with its strategic target, high differentiation, or both. For example Lexus competes in the luxury car segment, but within that segment it is following a strategy distinct from other luxury car companies. Its competitors might be seen as top-of-the-range

Mercedes and BMW. Against these competitors in this segment, Lexus is following a low-price or perhaps a hybrid strategy. Its quality is just as good, but relative to those other models, its prices are low. Focus may also be used to select targets least vulnerable to substitutes or where competitors are the weakest.

Focus strategy necessarily involves a trade-off between profitability and sales volume. Like the differentiation strategy, it may or may not involve a trade-off with overall cost position.

Stuck in the Middle

Overall cost leadership, differentiation and focus strategies are alternative, viable approaches to dealing with competitive forces. "Stuck in the middle" is a futile strategy. It is the firm that has failed to develop its strategy in at least one of the three directions. It is unclear as to its fundamental generic strategy such that it ends up being stuck in the middle'- a recipe for failure (Johnson and Scholes). Such a firm lacks the market share, capital investment, and resolves to play the low-cost game, the industry-wide differentiation necessary to obviate the need for a low-cost position in a more limited space.

The firm stuck in the middle either loses the high volume-customers who demand low prices or must bid away its profit to get this business away from low-cost firms. It also loses high-margin businesses to the firms who are focused on high-margin targets or have achieved differentiation overall. It also probably suffers from a blurred corporate culture and a conflicting set of organizational arrangements and motivation system. For example, a firm stuck in the middle must make a fundamental strategic decision either to achieve cost leadership or at Least cost parity, which usually involve aggressive investments to modernize and perhaps the necessity to buy market share, or it must orient itself to a particular target (focus) or achieve some uniqueness (differentiation). In some industries the problem of being caught in the middle may mean that the smaller (focused or differentiated) firms and the largest (cost leadership) firms are the most profitable, and the medium size firms are the least profitable.

2.3.1 Risks of the Generic Strategies

(i) Failing to attain or sustain the strategy

(ii) For the value of the strategic advantage to erode with industry evolution.

The three strategies involve differing types of risks. It is important to make these risks explicit in order to improve the firm's choice among the three alternatives.

Risks of Overall Cost Leadership

Cost leadership demands that the firm keep up its position by reinvesting in modern equipment, scrapping obsolete assets, avoiding product proliferation and embracing technological improvements. Achieving economies of scale is only possible through significant attention. Cost leadership is therefore vulnerable to the following risks:

i) technological change that nullifies past investments or learning;

ii) low-cost learning by industry newcomers through imitation or through their ability to invest in state-of-the-art facilities;

iii) inability to see required product or marketing change because of the

iv) attention placed on cost;

v) Inflation in cost that erodes the firm's ability to maintain enough of a price differential to offset competitors' brand images or other approaches to differentiation.

Ford Motor Company is a classic example of the risks of cost leadership of the 1920's. It achieved unchallenged cost leadership through limitation of models and varieties, aggressive backward integration, highly automated facilities, and aggressive pursuit of lower costs through learning. Learning was facilitated by the lack of model changes. However, when the market began placing more of a premium on styling, model changes, comfort, and closed rather than open cars, customers were willing to pay a premium to get such features. Ford faced enormous costs of strategic readjustment given the rigidities created by heavy investments in cost minimization of an obsolete model.

Risks of Differentiation

i) The cost differential between low-cost competitors and the differentiated firm becomes too great for differentiation to hold brand loyalty. Buyers therefore sacrifice some of the features, services or image possessed by the differentiated firm for large cost savings.

ii) Buyers' need for the differentiating factor falls. This can occur as buyers become more sophisticated.

iii) Imitation narrows perceived differentiation, a common occurrence as industries mature.

Risks of Focus Strategy

i) The cost differential between broad-range competitors and the focused firm widens to eliminate the cost advantages of serving a narrow target or to offset the differentiation achieved by focus

ii) The differences in desired products or services between the strategic target and the market as a whole narrows

iii) Competitors find submarkets within the strategic target and outfocus the focuser.

The firm achieving focus may also potentially earn above-average returns for its industry. Its focus means that the firm either has a low cost position with its strategic target, high differentiation, or both. Both cost-leadership and differentiation positions provide defenses against each competitive force.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter details the research design used to achieve the objectives of the study.

3.2 Research Design

The design of this research is a sample survey of public health facilities in Kenya. The research study is to find out the challenges that the public health institutions consider to come from other health providers and the strategies they use against these challenges. This therefore entails studying a sample of health institutions from the public sector.

3.3 Population of the study

Include all public health institutions in Kenya.

3.4 Sampling Design

The sample will include one central referral hospital, two provincial hospitals, five district hospitals and four health centers.

The above sampling method is chosen because the Kenya health management structure is in four levels: central, provincial, district and health centers. 1 out of 2 hospitals is selected at the central level, 2 out of 7 at the provincial level, 5 out 102 at the district level and 4 out of 460 at the health center level. All the public health institutions within each of the above levels form the public health institutions within the Ministry of Health as an organization. All the facilities within each level are rather homogeneous in that they have identical opinions on one issue. For this reason a few study units are selected from each level which will be most representative of the whole population.

3.5 Data collection method

The study will use primary data. The data collection instrument will be a semi-structured questionnaire comprising of eighteen (18) both open and close-ended

questions. Primary data will be collected through interview using an interview guide (see appendix). Respondents will be administrators' In-Charge of Hospitals, Matron-In-Charge, Medical Superintendents and Health Care Finance Secretariat. The questionnaire will be divided into three parts. Part A. will collect general information. Part B. will comprise questions that determine the challenges from the environment, and part C will invite responses to questions on the strategies used by the public health sector to response to the challenges.

3.5 Data Analysis

The primary data obtained will be subjected to quantitative techniques of analysis as follows:

Descriptive statistics such as summarized tabulations of frequencies mean, median, mode, percentage and rankings to show the similarity of factors that challenge the public health institutions in the provision of health services.

Ratio analysis will be used to analyse the ratio of patients to workers and percentages to identify the key factors that influence the provision of quality health care services.

CHAPTER 4: DATA COLLECTION AND ANALYSIS

4.1 Introduction

This study sought to establish the challenges of competition faced by public health institutions in Kenya and the competitive strategies used by them to counteract the challenges. The method of data collection used was questionnaires. The questionnaire had open-ended questions, rating scales, multiple choice and dichotomous questions. The data collected was analysed using descriptive statistics.

The analysis and findings of the study are presented in two major sections. The first section looks at the challenges of competition encountered by public health institutions while the second section examines the strategies deployed by the same health institutions to counteract the challenges.

4.2 General information of the institutions

This section contains data collected by structured direct questionnaire. The data was to provide general information of every institution studied. The respondents who were mainly Health Administrators and Medical Record Officers were asked to state when their facilities were established.

Table 1: Year of Institution Establishment

Year of establishment	Frequency
1901	1
1916	1
1920	1
1921	1
1922	1
1957	1
1969	1
Total	7

Source: Research Data

n = 7

Five (7) out of twelve (12) facilities responded and all were at the provincial and district levels. The oldest was Kenyatta National Hospital started in 1922 while the most recent was Nyanza Provincial Hospital built in 1969. The range between the

oldest and the most recent hospital was 68 years. All of them were established before 1970.

Again respondents were asked to state all the number of the different cadres of employees they have from doctors, nurses to support staff. This was to indicate the uneven distribution of medical staff in the country.

Table 2: Staff Establishment of Sampled Facilities

Health Institutions and Numbers of Professional Cadres.

No. of staff	Doctors	Nurses	Clinical Officers	Other Paramedics	Health Admin	Support Staff
Below 1	4	0	0	0	4	0
1-10	2	4	4	1	7	4
11-20	1		2			
21-40	1	1	4		1	
41-60	2		1			3
61-80	1		1	3		3
81-90				1		
121-150				2		
181-200		2				
201-300	1	3				
401-450		1				
601-650				1		
800-850						1
1650-1680		1				
Total	**12**	**12**	**12**	**8**	**12**	**11**

Source: Research Data
n = 12

From the table, one institution had between 61 and 80 doctors while 4 institutions (H/Cs) had none (0). However the national referral hospital had between 201 and 300 doctors. Four (4) institutions had between 1 and 10 nurses while another had between 401 and 450. Referral had between 1650 and 1680. The institution with the least number of clinical officers had 1 while the highest had 61. It is evident that the ranges between the highest and the lowest number of staff in each cadre are quite large.

They were further asked to state the bed capacities of their institutions and the volume of work load per month both in-patient and out-patient.

Table 3 (a): Bed capacity of Health institutions

Bed Capacity	Frequency
Below 50	1
200 - 250	1
300 - 400	2
400 - 500	2
550 - 600	1
1750 - 1850	1
Total (n)	**8**

Source: Research Data

The respondents were the national referral hospital, the provincial and the district hospitals. The institution with the highest bed capacity had 1800 while the lowest had 49.The facility with the lowest bed capacity was upgraded from a health centre a few years back and has expanded to a bed capacity of 49. It had a nurse patient ratio of 1: 151 and a doctor patient ratio of 1: 116. According to the Nursing Council, the recommended in-patient nurse ratio is 1: 6 while out-patient is 1: 50. The patient worker ratios indicate that the professional staffs are over loaded.

4.3 Challenges from public health institutions

This section addresses the first objective of the study which aims at determining what public hospitals consider as challenges from the public health institutions. The kind of data collected was statistical. Question 1 was a structured open-ended question which was aimed at finding out the meaning of quality health care services. Knowledge of quality health care is supposed to equip health staff with the required kind and standard of services that are expected by patients.

Table 4: The meaning of quality health care

Meanings	Frequency (F)	Percent (%)
Improved health services that give value to its users	4	40
Health services which are available and affordable	2	20
Availability of drugs, clean x-ray films and all health services	2	20
Accessible, adequate and affordable and efficient health care services	2	20
Total	**10**	**100**

n = 10

Source: Research Data

The table above indicates that the majority of the respondents which form 40% of the responses stated that quality health care meant improved health services that give value to its users. However 20% cited availability of drugs, clean linen, x-ray films and all health services, 20% stated health services which are available and affordable, and another 20% accessible, adequate and efficient healthcare. It is evident that a large percentage of the respondents concur that the meaning of quality healthcare is improved health services that give value to its users.

Question 2 examined the areas of challenges that are faced by public health institution and their extent. Data was collected through a five point rating scale where 1 = No constraint at all, 2 = A little constraint, 3 = Average constraint, 4 = A great constraint, 5 = Avery great constraint. The higher the mean score the greater the challenge and vice versa

Table 5: The sources and extent of challenges faced by public health institutions

Challenges from private health institutions	Mean	Std Dev.
Availability of drugs and pharmaceuticals in private hospitals	2.6	0.8
Better drugs in private hospitals	1.5	0.9
Adequate finances	3.3	1.5
Better customer care	4.0	1.2
Advanced technology	3.3	1.6
Motivated staff	3.0	1.1
Better facilities	3.0	0.9
Better nursing care	3.5	1.5
More qualified staff	1.0	0.2
Adequate staff	2.7	1.2

n = 12

Source: Resource Data

From the above table the greatest challenge from private health institutions to public health institutions is better customer care with a mean score of 4.0. The second greatest challenge faced by public health institutions from the private sector is better nursing care with a mean score of 3.5. However, it is evident that private health institutions are faced by no challenge as far as qualified staff is concerned. This is indicated by a mean score of 1.0. Public health institutions are also faced with no challenge as far as the availability of better drugs is concerned with a mean score of 1.5. From the table, the general picture is that most institutions are either moderately or greatly constrained with availability of drugs and pharmaceuticals, adequate finances, advanced technology and better facilities in private health institutions. This is indicated with mean scores ranging from 3.0 to 3.3.

As far as adequate staff in the private health institutions is concerned it is evident from the picture that most institutions were either little challenged or were moderately challenged with an average mean of 2.7.

Question 3 examines the extent of the referrals made to private health institutions by public health institutions. A five point rating scale was again used to collect data. This was to indicate the inability of public hospitals to offer all services needed by patients.

Table 6: Reasons and extent of referrals to private institutions

Challenges	n	Mean Score	Std. Dev.
X-ray / scanning	9	2.3	0.7
Laboratory	11	1.8	0.75
Drug/pharmaceuticals	11	2.3	0.9
Physiotherapy	10	1	0.0

Source: Research Data

It is evident from the table that x-ray services, drugs and pharmaceuticals form the bulk of referral services to private health institutions and as a result the institutions moderately refer their patients to private for the services. Physiotherapy services are not a challenge at all from the private institutions as indicated by the mean score of 1 and a standard deviation of 0. However, laboratory services pose little challenge as evidenced by a few referrals which are made with a mean score of 1.8 and a standard deviation of 0.75.

Questions 4 and 5 examine the existence of part-time practice and locums in private health institutions that attract staff from public health institutions to engage in part-time practice.

Managers were asked if they engaged in part-time practice and if they knew of any staff who engaged in the practice. All facilities in the sample (n=12) responded.

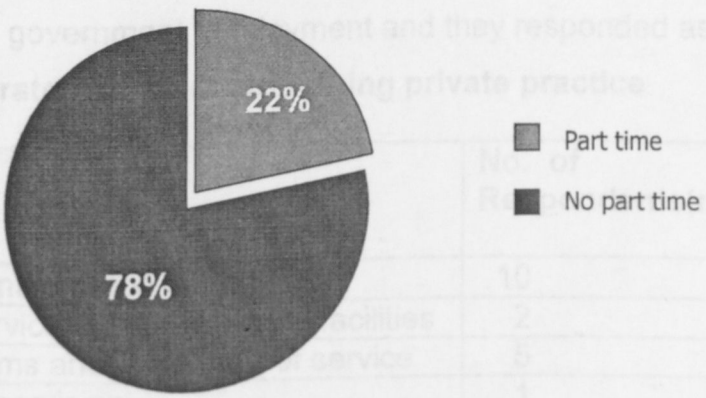

Figure 1: Engagement in Part Time Practice

22% of the managers stated that they never engaged in part-time practice or in locum while 89% of the managers stated that they knew other staffs who engaged in the practice. It is evident from the pie-charts that a small percentage of managers engage in part-time practice while a large percentage of managers know other staffs who engaged in the practice.

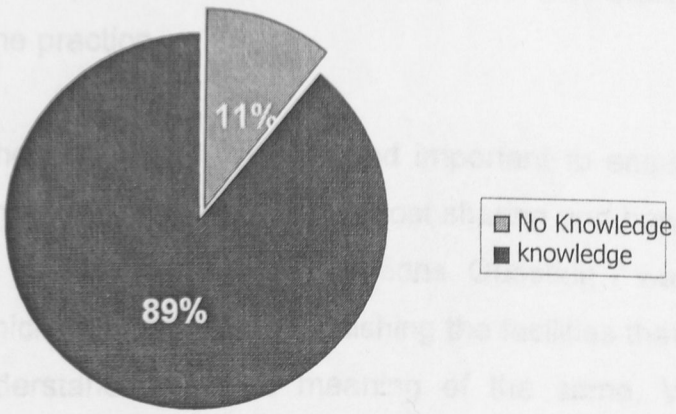

Fig 2: Managers knowledge of staff engaged in part time work.

After examining the challenge posed by private institutions part-time practice/locum, it was felt that there was need to come up with ways to discourage the practice. Q6 was therefore an open-ended question which aimed at finding the strategies that could be used to discourage private practice. Respondents were asked what the government could do to discourage the health professionals from engaging in private practice while still in government employment and they responded as follows:

Table 7: Strategies for discouraging private practice

Strategies	No. of Respondents(n)	Percent (%)
Improve remuneration	10	52.6
Improve services in public health facilities	2	10.5
Improve terms and conditions of service	5	26.3
Improve supervision	1	5.3
Maintain available equipment in working condition	1	5.3
Total responses	**19**	**100**

n = 11

It is evident from the table that the largest number of respondents (52.6%) stated that the government should improve the remuneration of staff. This was followed by 26,3% who stated that the government should improve terms and conditions of service and 10.5% that indicated that services in the public health facilities should be improved. It is also evident that a number of institutions that stated that the government should improve the remuneration of staff also stated one more strategy for discouraging the practice.

After examining the challenges it was found important to ensure that public health institutions staff understood the meaning of cost sharing and how it has been used by private institutions to challenge public institutions. Question 7 was therefore an open-ended question which was aimed at establishing the facilities that charge cost sharing fee and their understanding of the meaning of the same. When asked if their institution charged cost sharing, 100% responded positively with a mean score of 1.

Table 8: Meaning of cost sharing

Meaning	No. of responses	Percent (%)
Sharing health services Costs with donor	1	8.3
Patients sharing treatment Costs with govt.	8	66.7
Improve and fund hospitals for better services	1	8.3
Public assisting govt. in providing better h/care services.	1	8.3
Sharing treatment costs between patient & employer	1	8.3
Total	**12**	**100**

n = 12

Source: Research Data

It is evident from the table that the largest percentage (66.7%) of respondents indicated that cost sharing meant that patients had to share treatment costs with the government. Understanding Cost Sharing in terms of other meanings as shown in the table each had 8.3 percent of respondents. It is evident that most of the responses have more or less the same meaning.

Questions 8 and 9 are aimed at finding out the challenges from private health institutions as a result of introducing cost-sharing. Respondents were asked about the reactions of patients to the introduction of cost sharing. All the respondents stated that fewer patients initially seeked medical services from public health institutions. However, the number of private firms in the health sector increased as portrayed in the pie-chart below.

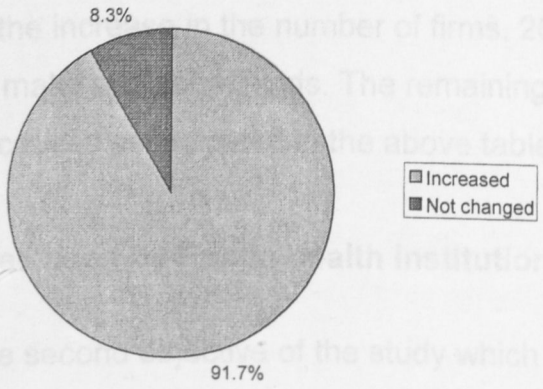

Figure 3: The Numbers of Private Firms in the Health Sector have increased since 1989.

It is evident from the pie-chart that a large number of respondents (91.7%) concurred that the number increased.

It was also felt that it is important to explore other factors that caused the increase in the number of private firms in the health sector. Using an open-ended question respondents were again asked to state what could have caused the outcome from question 9.

Table 9: Causes of increase in the number of firms

Causes	Frequencies (F)	Percent (%)
Increase in the number of patients	3	20
Increase in population	2	13.3
Relaxed regulations on private practice	1	6.7
Deteriorating services in public health institutions	3	20
Introduction of cost sharing in public hospitals	1	6.7
Higher charges by public health facilities	1	6.7
Increase in demand for health services	1	6.7
Need to make additional funds by private facilities	2	13.3
Patients did not want to spend money & more time	1	6.6
Total responses	**15**	**100**

n = 12

From the table it is indicated that a large number of respondents (40%) indicated that increase in the number of patients and deteriorating services in the public health institutions contributed to the increase in the number of firms. 26.6% stated increase in population and need to make additional funds. The remaining number of respondents stated other causes as indicated in the above table.

4.4 Competitive Strategies used by Public Health Institutions

This section addresses the second objective of the study which aims at identifying the competitive strategies used by public health institutions to counteract competition from private health institutions. The kind of data collected was mainly descriptive and used a five point rating scale where 1 = Not at all, 2 = to a little extent, 3 = averagely, 4 = a great extent, 5 = a very great extent. The higher the mean score the more popular the strategy. Question 10 looked at the various strategies and the extent that they are used by facilities to counter challenges from the various health institutions.

Table 10: The extent which facilities use the various strategies

Strategies	n	Mean	Std
Comparable quality consultation services at same price as private hospitals	12	1.8	1.4
Comparable quality health services at lower price Than private institutions	12	4.1	1.2
Availing similar drugs and pharmaceuticals at lower price than private and other health institutions	12	4.0	1.1
Offering comparable x-ray and laboratory services at lower costs than private health institutions	12	4.0	1.3
Offering transfer and ambulatory services at lower costs than private health institutions	12	3.8	1.7
Superior quality health consultation services at Lower costs than private health institutions	12	3.8	1.2
A few better quality x-ray services(better clarity) at lower costs than private health institutions	12	2.5	1.6
Offering superior quality in-patient services at slightly the same or lower price than private inst.	12	2.8	1.3
Better customer services to those who can afford at Comparable or lower costs than private & other inst.	12	2.2	1.6
Offering better nursing care to those who can afford.	12	2.2	1.6

Source: Research Data

From the table it is evident that offering comparable quality health services at lower price than private health institutions indicated by a mean score of 4.1 is a strategy which is greatly used by public health institutions. Other strategies which are equally greatly used by public health institutions are availing similar drugs and pharmaceuticals and offering comparable x-ray and laboratory services at lower costs than private and other health institutions both indicated by mean scores of 4.0. Others are offering superior health consultation services and transfer and ambulatory services at lower costs than private health institutions both with mean scores of 3.8.

Strategies that are moderately used by the same institutions are: Offering a few better quality x-ray services at lower costs than private health institutions; offering superior in-patient services at slightly the same or lower price than private institutions and better customer services to those who can afford at comparable or lower costs than private and other institutions. These are indicated by mean scores of 2.5 and 2.8 respectively.

Offering better nursing care to those who can afford and offering comparable quality consultation services at same price as private hospitals is either used to a little extent by public health institutions as indicated by mean a score of 2.2.

Questions nos.11 to 14 were analysed using descriptive data with dichotomous (yes/no) and open-ended questions. Q. 11 was specifically aimed at finding out the extent that public health institutions have introduced amenity in-patient wards as a strategy to challenge private competition and to indicate how it is used as a strategy.

Respondents were therefore asked if their amenity wards function. 58.3% responded that their amenity wards were in function, while 41.7% indicated that they did not function (pie-chart).

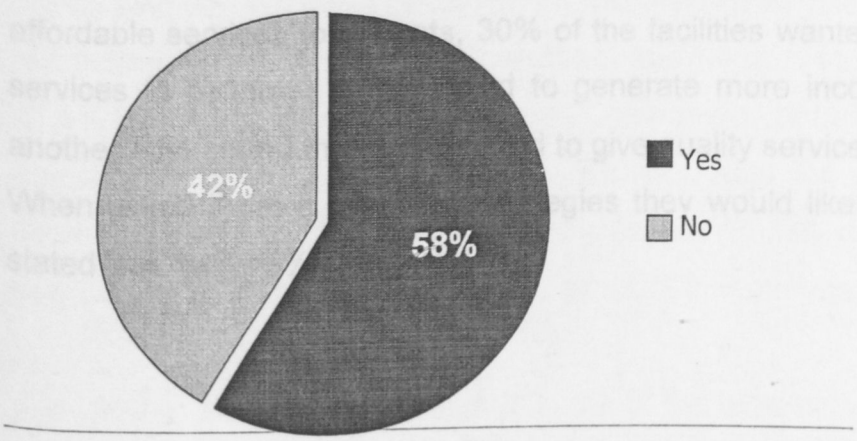

Fig 4: Functioning amenity wards

Those who responded positively were again asked to give the reasons of introducing amenity wards in their institutions.

Table 11: Reasons for introducing Amenity wards

Strategies	(F) No. of responses	Cumulative Percent (%)
Give quality service to staff	1	10
Offer quality & affordable services	4	50
Offer better healthcare services to Those who can afford	3	80
Generate more income for public Hospitals	2	100
Total	9	

n = 10

Source: Research Data.

Those who responded positively were then asked to give the reasons of introducing amenity wards in their institutions. 40% stated that they wanted to give quality and affordable services to patients, 30% of the facilities wanted to offer quality health care services to patients, 20% wanted to generate more income for public hospitals and another 10% stated that they wanted to give quality services to staff.

When asked if there are other strategies they would like to use but cannot use 91% stated 'yes' while 9% stated 'no'.

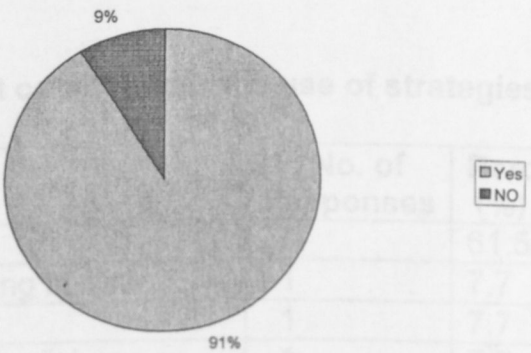

Figure 5: Other Strategies that Public Health Institutions would like to use.

Apart from the above strategy (amenity) the facilities felt that there were other strategies that they could like to use but were unable to use exhaustively. The following were stated as other strategies that could be used:

Table 12: Other strategies that could be used.

Other strategies	No. of responses	Percent (%)
Avail drugs for all ailments	1	5.6
Provide x-ray facilities (Those not provided)	6	33.3
Post adequate medical staff	4	22.2
Have amenity guidelines and policies for operations	1	5.6
Establish revolving amenity pharmacy	2	11.1
Operate separate amenity a/c to ease transactions	1	5.6
Increase health staff salaries	1	5.6
Increase limited bed capacity	1	5.6
Offer amenity services	1	5.6
Total	**18**	**100**

n = 12. *Source: Research Data.*

Those who were positive indicated the following strategies: 33.3% stated provision of x-ray facilities, 22.2% indicated that adequate medical staff be posted to the facilities, 11.1% indicated establishment of revolving amenity pharmacies. Other statements with percentages of 5.6% each were as follows: drugs for all ailments be availed, have amenity guidelines and policies, improve the limited bed capacities, offer amenity services, operate a separate amenity account and increase salaries to health staff.

They further stated the following as some of the causes that could hinder the use of the strategies:

Table 13: Causes that could hinder the use of strategies

Causes	(F) No. of Responses	Percent (%)
Insufficient funds	8	61.5
Negative attitude working in rural	1	7.7
Poor remuneration	1	7.7
Lack of guidelines and policies	1	7.7
Strict govt reg. on opening pub. Inst.	1	7.7
Cumbersome procurement procedures	1	100
Total	**13**	

n = 12.
Source:Research Data.

61.5% of the facilities indicated that the use of the above stated strategies would be hindered by lack of sufficient funds. The rest of the respondents with percentages of 7.7 each stated as follows: Negative attitudes toward working in rural areas, poor remuneration, strict government regulations on opening public facilities, lack of guidelines and cumbersome procurement procedures. It is evident from the table that insufficient funds is the biggest problem in implementation of the stated strategies

It was realised that human resource is a very important factor in the implementation of strategies in all organizations. Question 13 was therefore aimed at finding out how public health institutions have been able to retain their professional staff. Question 13 requested respondents to state the strategies that they have used to retain professionals like doctors, nurses and other clinicians in the past. The following strategies were stated:

Table14: Strategies public facilities have used to retain Professional staff

strategies	Frequencies (F)	Percent (%)
None	1	8.3
Govt improved terms of service	5	41.7
Given professional commission	1	8.3
Improved working conditions	2	16.7
Staff motivation	1	8.3
	1	8.3
Job security	1	8.4
Total	**9**	**100**

n = 9

Source: Research Data

41.7% indicated that the government had improved terms of service, 16.7% indicated improved working environment, 8.3% stated that professionals are given some profession commission, 8.3% indicated staff motivation such as tea, lunch etc and another 8.3% responded that there was no strategy. From the table it is evident that the government had to a large extent improved terms of service and working conditions of staff in order to retain their professional staff.

Question 14 was to indicate if there are any other strategies they would like to use but could not use to retain professional staff. The respondents indicated the following: 6.7% indicated that hardship allowance be given to those working in the rural areas, 60% improve remuneration, 10% reduce workload by employing more doctors and10% avail important services to patients.

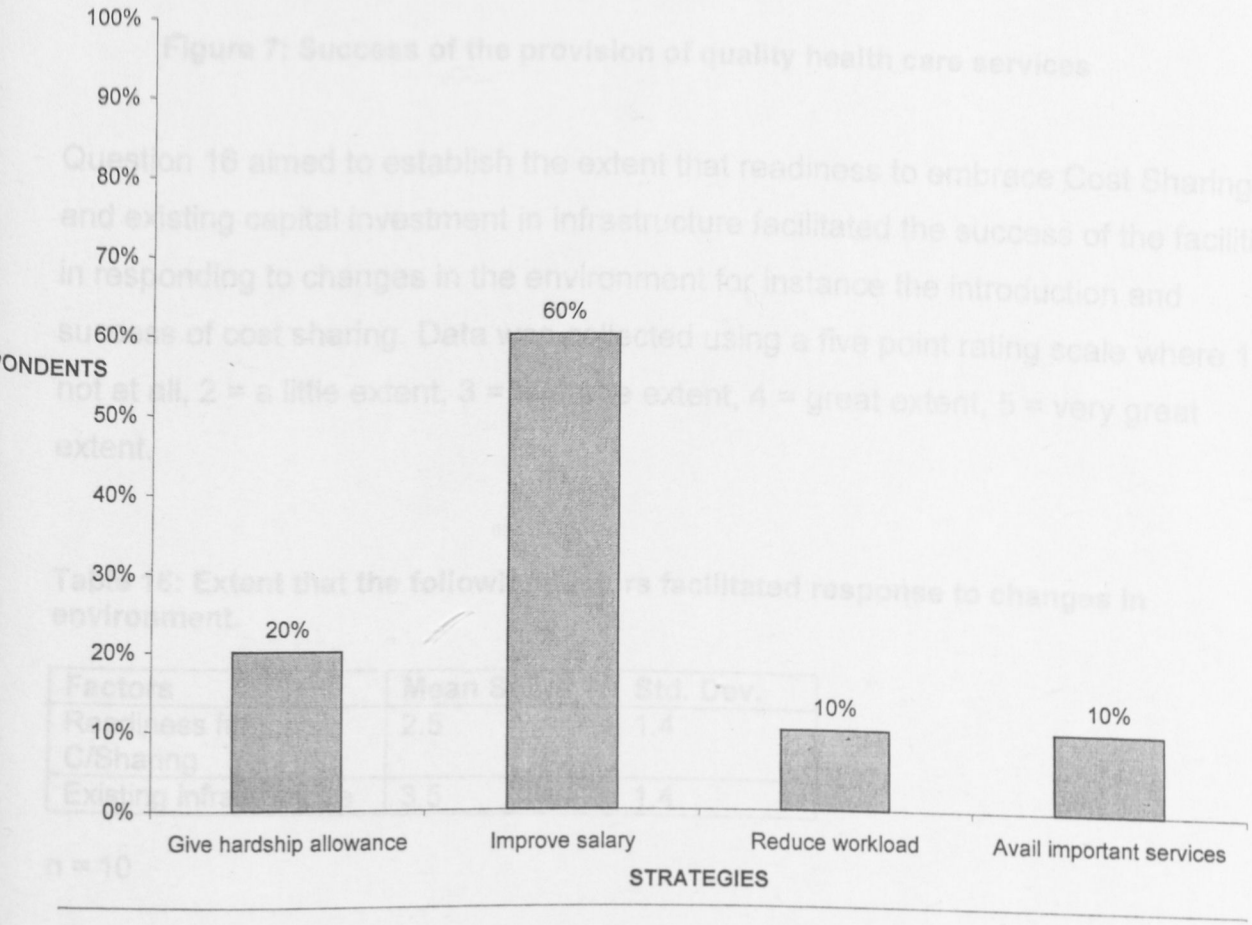

Figure 6: Other Strategies that could be used.

Respondents were asked to state how their facilities have survived as far as the provision of quality health care services is concerned (tick correct one). All facilities (100%) responded that they have survived by reducing their costs through efficient use of resources. 91.7% again stated that they discouraged corruption. All facilities (100%) again indicated that by improving workers skills through in-service trainings.

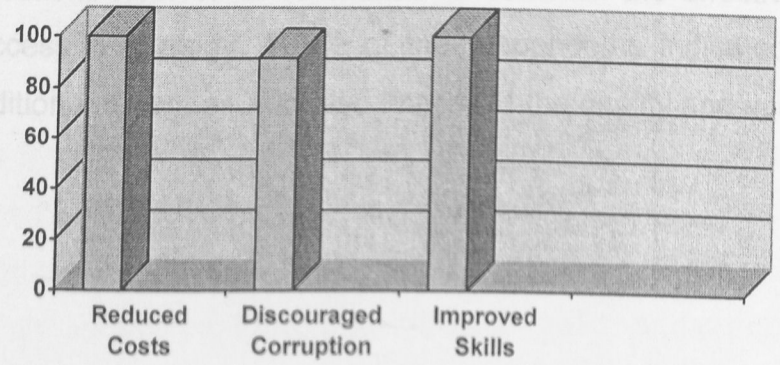

Figure 7: Success of the provision of quality health care services

Question 16 aimed to establish the extent that readiness to embrace Cost Sharing and existing capital investment in infrastructure facilitated the success of the facilities in responding to changes in the environment for instance the introduction and success of cost sharing. Data was collected using a five point rating scale where 1 = not at all, 2 = a little extent, 3 = average extent, 4 = great extent, 5 = very great extent.

Table 15: Extent that the following factors facilitated response to changes in environment.

Factors	Mean Score	Std. Dev.
Readiness for C/Sharing	2.5	1.4
Existing infrastructure	3.5	1.4

n = 10

When asked the extent that patients were ready to embrace the success of cost sharing, it is evident from the table that they were ready to embrace to a little extent with a mean score of 2 and a standard deviation of 1.4. However, respondents stated that the existing capital investment in infrastructure and state-of-the-art equipments facilitated their efforts in responding to changes in the environment either moderately or to a very great extent. This is indicated by a mean score of 3.5 and a standard deviation of 1.4

Questions nos. 17 & 18 wished to establish the effectiveness of Cost Sharing as a successful strategy. 100% of the respondents indicated that cost sharing provided additional revenues and also improved the quality and scope of services.

CHAPTER 5: SUMMARY, DISCUSSIONS AND CONCLUSIONS

5.1 Introduction

This is the final chapter that provides the summary, discussions and draws conclusions of the study. The chapter also highlights the limitations of the study and makes recommendations for further research, policy and practice. The findings of the study are summarised, discussed and conclusions presented in the order of the objectives of the study. The first objective of the study sought to determine the challenges that public institutions face from private health institutions and the second objective determines the competitive strategies that can be deployed to counter the challenges.

5.1.1 Challenges from Private Health Institutions

In summary, the results show that all the managers of the public health institutions studied had adequate knowledge of quality health care services. They were all faced with challenges from the private health institution and were able to identify their sources and extents. All of them charged Cost Sharing, a policy that was an opportunity but posed a threat from the private health sector.

The quality of health care services is the basis of competition and challenges in the health sector. Majority of the respondents which form 40 percent of the responses agreed that quality health care meant improved services that give value to its users. The alternative responses led to the same meaning. Quality health care meant provision of health services that are available, affordable, adequate and efficient. It further meant availing drugs and non pharmaceuticals, clean linen, x-ray films and all health services. As a result all the institutions studied strived to make their services available, adequate and efficient in line with the responses that they had given. The alternative responses which the institutions practised added quality to their services. This indicated that all the managers had knowledge of quality health care services.

Pearce and Robinson (1997), states that the external environment is dynamic. It continuously causes new challenges in terms of opportunities and threats. Due to its uncontrollability, firms need to adjust to changes by adapting to them in order to succeed.

The institutions can only adapt to them if they have knowledge of what they are. The public health providers understand the kind of services they want to give to their users. The knowledge they have of quality health care services can enable them to relate their organisations to the environment and to cope with competition. An institution cannot give quality services if it does not know or understand the attributes that contribute to quality health care services.

All the public health institutions studied were faced with challenges from private health institutions. All of them were able to identify the sources of the challenges, and their extents which varied from one institution to another. The greatest challenge from the private health institutions faced by public health is better customer care followed by better nursing care. Incidentally even the public health institutions that faced very few challenges were faced with these two challenges. They are also moderately challenged adequate finances, advanced technology, motivated staff, better facilities and availability of drugs in the private health institutions. However, they have all the qualified staff in the public health institutions. Better drugs in the private health institutions are not a challenge to them.

The greatest challenges as far as better customer and nursing services were concerned came from the general wards. In some of the health institutions, patients were forced to have relatives who took care of their nursing care. Most of the general wards were congested with patients with very few nursing staff allocated to give them nursing care. Ward rounds done by doctors were more hectic as one consultant had to see all the patients in one or two wards. Patients in amenity wards were however given better nursing and customer care because they were able to pay for the services. Amenity wards in most hospitals were full, but not congested. Amenity wards unlike the general wards did not admit patients beyond their bed capacities because admitting more patients could compromise the quality of customer and nursing care. The health workers working in amenity wards were more satisfied with their work than those in the general wards because they were paid commissions apart from their salaries. Majority of them would have liked to work in the amenity wards. However, some of them had to be deployed in the general wards. Although faced by shortage of staff, the few available

were all qualified in all the public health institutions. Patients got all the common drugs from the hospital pharmacies but some were referred to private chemists and institutions for special drugs which the hospital could not afford to buy and stock.

Porter (1998) stated that knowledge of the underlying sources of competitive pressure provides the groundwork for a strategic agenda of action. The staffs in public health institutions were able to identify the sources of their challenges because they had knowledge of quality health care. Amenity wards were institutions where quality health services were offered in the public sector set up. This means that given enough funds and all the needed essentials, the public health institutions could provide quality health care services. If an institution understands well the kind of services that it wants to offer it is able to achieve and provide quality health care to its users. Porter further states that the strategist must analyse the sources of competition to find out what makes the industry vulnerable to those forces. It is knowledge of quality health care services that has enabled the public health institutions to analyse and to come up with amenity wards. It has further enabled them to identify the quality of services in the private hospitals that make the private institutions to challenge them.

The public health institutions were able to identify policies that posed opportunities as well as threat them. Such policies were being exploited by the private health institutions to challenge the public health institutions. For instance, the number of private firms in the health sector increased since 1989. Majority of the health institutions believed that it was the increase in population that brought about the increase in the number of patients and the deteriorating services in public health institutions. Alternative suggestions were the introduction of Cost Sharing in private hospitals; need to make additional funds by private hospitals and also the fact that patients did not want to spend more money and time in public hospitals were other alternative challenges faced from the private health institutions. It is however clear that the introduction of Cost Sharing coupled with the deteriorating services in the public health institutions could have encouraged the private health institutions to chip in to make additional funds as they are profit oriented. Since both private and public health institutions were now charging for their services, competition for patients was now and has been based on the quality of heath care

services provided by the two competitors among other factors. Public health institutions have competed against the private sector with an upper hand in some districts, for instance Kisii Central.

From the foregoing discussion it can be concluded that all the public health institutions have knowledge of quality health care services. They know what can add value to their services thereby providing quality health care services to their patients. Equipped with this knowledge they have been able to identify the challenges that they face from private health institutions. It is therefore important that all public health institutions understand the attributes of quality health care services and be able to identify them. This will enable them to take action whenever they have an opportunity. For instance, if funds and other essentials that provide quality health care are availed they can be able to provide to patients services that give value to them.

5.2 Competitive Strategies used by Public Health Institutions

The second objective sought to determine the competitive strategies adopted by public health institutions to counter competition from the private sector. In summary, among the public health institutions studied all of them deployed strategies to counter challenges from the private sector and at the same time offer affordable services to their users. The most greatly used strategy was offering comparable quality health services at lower price than private institutions, followed by availing similar drugs and non pharmaceuticals and offering comparable x-ray and laboratory services than private and other health institutions. Offering comparable quality consultation services at same price as private hospitals and better nursing and customer care to those who could afford are strategies which were least effectively used. Other strategies which were moderately used are by offering superior health consultation and in-patient services at same or lower costs than private health institutions. Most of the public health institutions had established or built amenity wards to counter challenges from the private institutions. 58.3 percent had their amenity wards functioning, while 41.7% which were health centre facilities and one district institution did not have amenity wards. Majority of the health institutions (91%) had other strategies they would have liked to use to counter competition. They also had other strategies that they could use to retain professional staff but they could not use due

to other hindrances. In spite of the hard times most public health institutions have barely survived through deploying cost reduction strategies.

The above summary explains that the public health institutions deployed Overall Cost Leadership and Focus strategies to counter challenges from the private sector. Overall cost leadership strategy is one of the three generic strategies identified for creating a defendable position in the long run. Johnson and Scholes (2003) states that a low price strategy seeks to maintain a low price than competitors whilst trying to maintain similar value of product or service to that offered by competitors. This explains why public health institutions have deployed this strategy in the delivery of almost all their services. Outpatient consultation and inpatient fee are cheaper in public hospitals than in private hospitals because most public hospitals can lower their charges to cost recovery. Because private health institutions have to maximise their profits, they cannot be able to lower their prices below their costs. Through basing their competition on price, public health institutions have been able to counter competition from the private sector.

Cost leadership requires among other factors aggressive construction of efficient-scale facilities and vigorous pursuit of cost reduction from experience. This explains the reasons why all the public health facilities established amenity wards where existing capital infrastructure could accommodate or built where the existing infrastructure could not accommodate. Amenity wards generate more funds because patients admitted are ready to pay for the services. The services offered in these wards are superior and are offered at the same or slightly lower price than private health institutions. This further explains why all facilities reduce their costs through efficient use of resources as a survival tactic and also improve their workers skills through in-service trainings. 91.7 percent further discouraged corruption as a survival tactic.

Focus strategy focuses on a particular buyer group, segment of the product line or geographic market. The entire focus strategy rests on the premise that the firm is thus able to serve its narrow strategic target more effectively and efficiently than competitors who are competing more broadly. This is the reason why focus strategy has been deployed by public health institutions in amenity wards. Amenity wards targets those who

can afford where the patients are offered superior consultancy, better nursing and customer care services similar or better than private health institutions. In the provinces and districts patients prefer these wards to private health institutions and this has enabled these facilities to compete with an upper hand where they have well established amenity wards.

From the foregoing discussion it can be concluded that it is important that public health institutions understand that they have commodity –type products and services where competition is on the basis of prices. This makes it more challenging as tactical advantage may be gained by reducing price which is likely to be followed by competitors. They should also understand that low cost in itself is not a basis of advantage if competitors can also achieve the same low cost. The public health institutions should strive to expand their amenity services in order to generate funds that can effectively run the general wards and provide other essential services to those who cannot afford.

5.3 Limitations of the study

The researcher faced a few challenges when carrying out this study. To begin with, although only a few most representative units (institutions) were collected from each level of the population, the units (institutions) were far a part and the researcher had to travel a lot. This involved using finance which was quite scarce. It was also difficult to interview the records officers and the clinicians at the same time. Therefore the Medical Records officers left to fill the general information on their own. Most Record offices did not have readily prepared data due to shortage of record staff. This made data on work load, staff patient ratios and bed capacities from health centre institutions neither to be availed nor questionnaires to be fully completed on part one (general information). Secondly, Medical records staff from different institutions had different methods of calculating staff-patient ratios as some of them were perceived by the researcher to be more comprehensive than others. Most health centres did not have year of establishment because all of them had neither a Health Administrative nor a Medical Records Officer to take care of such administrative data. One institution which was very important to the researcher had a very frustrating process of approving requests for research applications. This frustrated

this researcher a lot. Eventually she was allowed to carry out her research after many months of communication in person, through letters and paying some research fee.

5.4 Recommendations for further research

The advent of HIV/AIDS has further created a fertile ground for competition between the private and the public sectors. In both the Nation and Standard newspapers of 28th April, 2006, the Gold Star Network was launched. Its aim is to ensure a reliable supply of affordable antiretroviral drugs and provision of other services to patients through services that they claim are not purely profit oriented (private). Its belief and source of drive is that HIV patients prefer to be seen in private clinics because they are perceived to be efficient and guarantee confidentiality. KMA will set payments for consultants, testing and medicine for the benefit of doctors and their patients. Future scholars can carry a study on the challenge(s) posed by the Gold Star Network and also find out the strategies the public health sector have used to manage and treat their HIV patients. They should further research on the strategy the public health institutions intent to use in future to deal with the issues efficiency and guarantee of confidentiality to their HIV patients. Scholars can also carry out research on attitude change behaviour of public health staff that will enable the public health institutions to provide better customer and nursing care in out patient and in the general wards.

5.5 Recommendations for policy and practice

The Ministry of Health should employ more staff and distribute them according to the patient population and needs of each health institution throughout the nation. This will reduce the time that patients spend on the queue while waiting for services and also improve both nursing and customer care services in the public health institutions.

It should further expand bed capacities in amenity wards in the existing institutions to reduce the number of patients who are sent away due to lack of accommodation. Amenity wards should be built in those facilities that do not have them at the district levels.

Administrative staff should be provided with competent administrative skills in strategic management of health institutions based in the present dynamic health sector environment.

REFERENCES

Ansoff, H. I. and Mc Donnell, E.S. (1990), **Implanting Strategic Management**, 2nd Edition, Prentice Hall.

Collins, D., et al. (1996), **Health Financing Reform in Kenya: The Fall and Rise of Cost Sharing, 1989-94,** Management Sciences for Health.

Dumm, J. K., et al. (1992), **Helping Services Meet Demand**, Center For Communication Programs, The Johns Hopkins University, Baltimore.

Gallacchi, A., et al. (1998), **Policy Briefs On the "Capacity of the Non Government Health Providers in the Delivery of Health Care in Kenya", The Shift of Responsibility of Health Care to the Private sector: A Viable Option?** Health Sector Support Programme.

Griffin, C. C. (1998), **User Charges for Health Care in Principle and Practice,** Economic Development Institute Seminar Paper 37, World Bank, Washington , DC.

Hax, A.C. and Majluf, N. (1996), **The Strategy Concept and Process: A Pragmatic Approach,** 2nd Edition, Prentice Hall, New Jersey.

Johnson, G. and Schole, k. (2002), **Exploring Corporate Strategy**, 5th Edition, Prentice Hall, pp 101-145.

Kutzin, J. (1994), **Experiencing with reform in the Financing of the Health Sector,** Division of strenghthening of Health Services, World Health Organization, Geneva.

Litvak, J. L. and Bondart, C. (1993), User Fees plus Quality Equals Improved Access to health Care: Results of a Field Experiment in Cameroon,

Social Science and Medicine, pp 369-83.

McPake, B. (1993a): " User Charges for Health Sevices in Developing Countries: A review of the Consumer Literature". **Social Sciences and Medicine,** vol. 36(11): pp 1383-95.

Mwabu, G., et al. (1995), "User Charges in Government Health Facilities in Kenya: Effect on Attendance and Revenue". **Health Policy and Planning**, vol.10(2): pp 164-70.

Newbrander, w.,et al. (2001), **User Fees for Health Services: Guidelines for Protecting the Poor,** Management Sciences for Health, Inc. Boston , M. A.

Pearce, J. A. and Robinson, R.B (1997), **Strategic Management : Strategy Formulation and Implementation and Control,** 6th Edition, Irwin, Homewood Illinois, pp 61-99.

Porter, M. E. (1998), **Competitive Strategy: Techniques for Analysing Industries and Competition,** New York Press, USA.

Shaw, R. P. and Griffin, C. C. (1995), **Financing Health Care in Sub-Saharan Africa through User Fees and Insurance,** The International Bank for Reconstruction and Development, Washington, DC.

Shipp, p. J. and Kiugu, S. (1991), **Calculating Staffig Requirements for Four Hospital Cadres in Government Hospitals in Kenya Using Workload indicators of Staffing Need,** Kenya Health Care Financing Project, Management Sciences for Health.

Yoder, R. A. (1989), " Are People Willing and Able to Pay for Health Services? **Social Sciences and Medicine,** vol. 29 : pp 35-42.

---------- **Kenya's Health Policy Framework**, (1994). Ministry of Health.

---------- **Kenya's Health Policy Framework Implementation and Action Plans.** (1996). Ministry of Health.

----------**Report on Sustainability of Christian Health Institutions**, (2003). Faith Institute of Counselling.

----------**The National Health Sector Strategic Plan** : 1999-2004, Health Sector Reform Secretariat.

----------**The National Health Sector Strategic Plan** : 2005-2010, Health Sector Reform Secretariat.

APPENDIX 1: CONSENT EXPLANATION TO RESPONDENTS

My name is Margaret A. Banda and I am working at National Aids Control STI Program (NASCOP) under the Ministry of Health. Presently I am a student at the University of Nairobi undertaking a master degree in Business Administration (MBA).

As a Health Administrative Officer who is still working in a public health institution and has worked in several health institutions, I have observed the challenges that these institutions face in the process of achieving their goal that is, providing quality, affordable and accessible health care services to all those who need it. Those who need health care services include both the financially able and the vulnerable. Public health institutions have been the sole refuge of the financially vulnerable and have continued to strive to provide greater coverage of health services in the face of the dwindling economy and reduced government support

The title of my research topic is: The challenge of competition and competitive strategies used by public health institutions in Kenya.

The objectives of my study are to determine what public health hospitals consider as challenges from the private hospitals and the competitive strategies adopted by public hospitals to counteract these challenges.

The interview is of general questions related to public health institutions. The information I need will contribute to the challenges generally faced by all public health institutions and the strategies that could be adopted to counteract these challenges. The data collected will be used for study purposes only and will form part of the fulfilment of the requirement for my award of the degree of Master of Business Administration of the University of Nairobi. I shall greatly appreciate your help in responding to these questions. The interview will take about 15 to 25 minutes. Your name will not be written on this form except the name of the institution. Your participation in this study is voluntary and you have the right to refuse to participate or

answer any question that you feel uncomfortable with. If you change your mind about participating in the course of the interview, you have the right to withdraw at any time.

The decision to participate or to withdraw will not affect you whatsoever. If there is anything that is unclear or you need further clarification, I shall be delighted to provide it.

Among the health institution in the country Kenyatta National Hospital forms a unit of my small sample given that public health institutions face more or less similar challenges and have homogeneous opinions on the same issues. I have chosen Kenyatta National Hospital as a unit in my sample study to represent the public health institution at the national level. Secondly, between the two national referral hospitals, Kenyatta National Hospital is more convenient to me because I reside and work in Nairobi.

This study will benefit Kenyatta National Hospital and other public health institutions by contributing to the continued improvement of the provision of health services in all these institutions, to all those who need it. The information collected will therefore be useful in improving the quality and coverage of health care services in the same institutions. It will benefit the nation by enabling the policy makers and decision experts to come up with better policies and decisions that provide an enabling environment for the provision of improved healthcare services.

I confirm that I have read the relevant parts of the audit and do hereby give consent to participate.

Signed ----------

APPENDIX 2: QUESTIONAIRE

PART ONE: GENERAL INFORMATION

RESPONDANTS (ADMINISTRATOR AND IN-CHARGE RECORDS)

1. When was your facility established?

2. How many employees does it have?

   Doctors.....

   Nurses .....

   Clinical Officers ..

   Other Paramedics..

   Administration .....

   Support Staff .....

3. what is the nurse patient ratio?.....

4. What is the doctor patient ratio?

5. What is the bed capacity of your facility?

6. What is the volume of the work load per month?

   In-Patient per month.....

   Out-Patient per month.....

PART TWO: CHALLENGES FROM PRIVATE HEALTH INSTITUTIONS

Health Administrator and Clinician (Med. Supt/Matron In-Charge)

1. What does quality health care services mean?
2. To what extent is your facility challenged by private hospitals because of the following? Use a five (5) point rating scale where 1. No constraint at all, 2. A Little constraint, 3. Average constraint, 4. A great constraint, 5. Very great constraint.

	1	2	3	4	5
• Availability of drugs and pharmaceuticals in private hospitals	( )	( )	( )	( )	( )
• Better drugs (enhanced efficacy) in private hospitals	( )	( )	( )	( )	( )
• Adequate finances in private hospitals	( )	( )	( )	( )	( )
• Advanced technology in private hospitals	( )	( )	( )	( )	( )
• Better customer care in private hospitals	( )	( )	( )	( )	( )
• Better motivated staff in private hospitals motivation	( )	( )	( )	( )	( )
• Better facilities in private hospitals	( )	( )	( )	( )	( )
• Better nursing care in private hospitals	( )	( )	( )	( )	( )
• More qualified staff in private hospitals	( )	( )	( )	( )	( )
• Adequate staff	( )	( )	( )	( )	( )

3. To what extent does your facility refer patients to private health facilities for the following services? Use a five (5) point rating scale where 1= Not failed at all, to 5= great extend.

	1	2	3	4	5
• X-ray and scanning services	( )	( )	( )	( )	( )
• laboratory services	( )	( )	( )	( )	( )
• Drugs and pharmaceuticals	( )	( )	( )	( )	( )
• Physiotherapy services	( )	( )	( )	( )	( )

4. Do you sometimes engage in part-time private (locum) practice?

(1) Yes (2) No

If the answer is YES, what makes you engage in part time practice? Explain in brief.

5. Do other staff members that you know engage in part time practice?

(1) Yes (2) No

6. In your opinion, what can the Government do to discourage health proffesionals from engaging in private practice/ locum? Explain

---

---

7. (a) Does your facility charge cost sharing fees? (1) Yes (2) No

(b) What is your understanding of cost sharing? Explain

---

8. What were the reactions of patients when cost sharing was first introduced/ revised upwards in your institution? Tick ( )the corect one.

- Fewer patients seeked medical services ( )
- The number of patients increased ( )
- There was no change in number of patients ( )
- No patients came to hospital ( )

9. (i) In your opinion, since 1989, have the number of firms in the private health

sector

(a) increased ?

(b) decreased ?

(c) not changed?

(ii) What could have caused this outcome? Briefly explain.

PART THREE: COMPETITIVE STRATEGIES

Respondants (ADMINISTRATORS AND HEALHCARE FINANCE SECRETARIAT)

10. To what extent does your facility use the following strategies to counter the challenges from the private health institutions? Use a five (5) point rating scale where, 1. Not at all, 2. to a little extend, 3. averagely, 4. A great extend, 5. A very great extent.

	1	2	3	4	5
• offering comparable quality health care consultation service at same price as private and other health institutions	( )	( )	( )	( )	( )
• offering comparable quality health care consultation services at lower prices than private and other health institutions	( )	( )	( )	( )	( )
• availing similar drugs and pharmaceuticals at lower price than private and other health institutions.	( )	( )	( )	( )	( )
• Offering comparable X-Ray and laboratory services at lower prices than private and other health institutions	( )	( )	( )	( )	( )
• Transffer and ambulatory services at lower costs than private and other health institutions	( )	( )	( )	( )	( )
• Offering superior quality health care consultation services at lower costs to all patients than private and other health institutions	( )	( )	( )	( )	( )
• Offering a few better quality x-ray/ ultrasound services (with more clarity) at lower costs than private and other health facilties.	( )	( )	( )	( )	( )
• Offering superiour (unique) quality in-patient services at slightly the same or lower price than the private and other health institutions to those who can afford.	( )	( )	( )	( )	( )
• Offering better customer care services to those who can afford at comparable or lower costs than private and other health institutions.	( )	( )	( )	( )	( )
• Offering better nursing care to those who can afford at					

same or lower costs. ( ) ( ) ( ) ( ) ( )

11. Does your Amenity ward function?

(1) Yes (2) No

If YES, what were the reasons of introducing Amenity ward in your institution? Explain.

---

12. Are there any other strategies you would like to use but cannot use?

(1) Yes (2) No

(i) If YES, what are they?

(ii) What would hinder their use?

---

13. What strategies have you used to retain professional staff like doctors, nurses and other clinicians? Explain

---

---

14. Are there any other strategies you would like to use to retain them but cannot use?

A (Yes) B (No)

If YES, what are they?

---

15. By charging subsidized fee, how has your facility been able to make ends meet as far as the provision of quality health care services are concerned? Tick ( ) the correct ones.

- Using all revenue to purchase drugs and linen
- Reducing costs through efficient use of resources
- Improving workers skills through inservice training
- Requesting patients to buy essential medical supplies
- Discouraging corruption

16. To what extent did the following factors facilitate your efforts in responding to changes in the environment? Use the five point rating scale, where 1. Not at all, 2. A little extent, 3. Average extent, 4.A great extent, 5. A very great extent.

	1	2	3	4	5
• Patients ready to embrace cost sharing	( )	( )	( )	( )	( )
• Existing capital investment in infrastructure and state-of-the-art equipment	( )	( )	( )	( )	( )
• No particular factor	( )	( )	( )	( )	( )

17. Does cost sharing increase or provide additional revenue ?

A (Yes) B (No)

18. Does cost sharing improve the quality and scope of services?

A (Yes) B (No)

APPENDIX 3: SAMPLING FRAME OF THE PUBLIC HOSPITALS

National referral Hospital

1. National Referral Hospital

Provincial Hospitals

2. Nakuru Provincial General Hospital
3. Kisumu Provincial General Hospital

District Hospitals

4. Mbagathi District Hospital
5. Kiambu District Hospital
6. Machakos District Hospital
7. Kisii District Hospital
8. Bondo District Hospital

Health Centres

9. Lari Health Centre
10. Masimba Health Centre
11. Kabondo Health Centre
12. Industrial Area Health Centre