FACTORS AFFECTING THE ADAPTABILITY OF INTERNATIONAL HEALTH MANAGEMENT PRACTICES BY THE NATIONAL HOSPITAL INSURANCE FUND (NHIF) IN KENYA

By

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DECLARATION

This management research project is my original work and has not been presented to any other university for examination.

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This management research project has been submitted for examination with my approval as university Supervisor.

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DEDICATION

I dedicate this project to my family, Mr. and Mrs. Mbuvi, Faith, Welly, Janet and Ngina.

I also dedicate this project to my Holygan family.

ABSTRACT

The purpose of the study was to investigate the factors affecting the adaptability of international health management practices by the national hospital insurance fund (NHIF) in Kenya. The adoption of international health management practices is important to the government of Kenya not only to improve its customer service but also to acquire the international standards of health management.

To this effect, the general objective of the study was to determine the factors affecting the adaptability of international health management practices by NHIF. These international health management practices are namely Capitation and Fee-For-Service and are being used to administer the out-patient cover by NHIF. The specific objectives of the study were To establish the extent to which the NHIF management and workers have understood the international health management practices Capitation and Fee-For-Service; to establish the perception of the NHIF management and workers regarding the uptake of these international health management practices and to identify the specific factors that the management and workers of NHIF are facing as regards the uptake of international health management practices.

It was established that the initiative to introduce international health management practices by NHIF was a welcome change by the workers and that most of them were optimistic about its benefits. However there were a number of concerns noted that would affect how well this management practices, namely, Capitation and Fee-For-Service would be adapted by the workers and management of NHIF.

The study found that the workers needed more training on the workings of these two health management practices so as to understand them better and hence know how to apply them correctly in the running of NHIF. The study also found that most of the workers thought the premiums charged were high and that this also affected their willingness to see the implementation of the new practices work because it would also affect them as they are also deducted.

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LIST OF ABBREVIAIONS AND ACRONYMS

NHIF	National Hospital Insurance Fund
MoH	Ministry of Health
WHO	World Health Organisation
FFS	Fee-For-Service
OOP	Out Of Pocket
MDG	Millennium Development Goals
USA	United States of America
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immuno-Deficiency Syndrome

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CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

For a country to have economic prosperity, its citizens have to be in good health. There are many definitions of good health by various individuals, institutions and organizations but the commonly accepted definition across the globe is the definition by the World Health Organisation. WHO (1948) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health is such an important aspect of development that the United Nations has given it the major consideration in its Millennium Development Goals (MDG's). The MDG's are the most broadly supported comprehensive and specific development goals the world has ever agreed upon (United Nations Development Programme, 2010). They were adopted by world leaders in 2000 and are set to be achieved by 2015. They are both global and local and are tailored by each country to suit its specific development needs.

Among the eight MDG's, three of them focus on health. These are goal number four to reduce child mortality rate, goal number five to improve maternal health and goal number six to combat HIV/AIDS, malaria and other diseases.

The major aim of these MGDs is the eradication of poverty worldwide, which is an economic goal. The World Bank defines poverty as deprivation in well being. It comprises of many dimensions which include low incomes and the inability to acquire the basic goods and services necessary for survival with dignity. Estimates by the World Bank show about 1.4 billion people live below the international poverty line of US$ 1.25 a day in 2005, equivalent to more than one fourth of the developing world's population.

However, poverty incidence declined from 52 percent of the global population in the 1981 to 42 percent in 1990 and 25 percent in 2005. That proportion is expected to be 15 percent by 2015. Given the above trends, the MDG target of halving the 1990 poverty rate by 2015, remains within reach at the global level. Hence one of the ways that countries across the globe are pulling towards this is by improving their health sector.

World over it has been agreed that for there to be economic growth and gain, the health of its population has to be prioritized. African countries and especially Kenya have not been left behind in this endeavor.

In the last ten years, Kenya has introduced sweeping reforms in the health sector, among these is the construction of more hospitals, increased training of medical staff, deployment of these staff to areas that are diseased prone, establishment of health related research facilities across the country, improvement of the business process in the health sector and a country wide drive, through the National Hospital Insurance Fund to have its citizens enroll into health insurance. Hence the importance of the health of the people to any country cannot be over emphasized.

1.1.1 International Health Management Practices

In today's world, no nation exists in economic isolation. All aspects of a nation's economy – its industries, service sector, levels of income and employment, living standard – are linked to the economies of its trading partners. This linkage takes the form of international movement of goods and services, labour, business enterprise, investment funds, and technology (Carbaugh, 2006). Recently, due to the rapid development of information technology, there has been an increase in the movement of information across nations. This movement has brought about what we term as globalisation.

The term globalization has had many definitions and has also been used interchangeably with other terms used to connote the internationalization processes but it has its own distinct meaning. Carbaugh (2006) defines globalisation as the process of greater interdependence among countries and their citizens. It consists of increased integration of product and resource markets across nations via trade, immigration and foreign investment – that is, via international flows of goods and services, of people and of investment such as equipment, factories, stocks and bonds. It also includes non-economic elements such as culture and the environment. This has brought about a shift of focus by most organizations from local to international. Firms become international in scope for a variety of reasons - a desire for continued growth, domestic market saturation, the potential to now exploit a new technological advantage, and so forth (Beamish et al, 1991).

Globalization has created a village out of the world economy. Most organizations are daily finding themselves in need of operating at global standards whether their focus and locus are

international or local. The rapid wide spread of information technology has made consumers aware of these standards and hence demand the same from all firms.

Increasingly, the World Wide Web has its presence in every country in the world, whether it is by satellite link or by cable connection. Most people are able to access information from anywhere in the world at the click of a button. This has made people aware of what is on offer in the global arena, and it has eventually shifted their consumer preferences from local to international standards.

Chang and Huang (2005) note that rapid changes in the operating environment such as globalization, changing customer needs and expectations and competition to provide innovative products have become the standard backdrop for many organizations. To enable these organizations compete effectively, it is critical that they constantly enhance quality of their products and services.

More to this, the issue is not only enhancing the quality of their products and services but also changing where necessary, these products and services to meet global standards while still tailoring them to suit the local needs.

The effect of globalization has not only been on the private sector but most African countries have implemented several changes in government policies in response to it (Kibor, 2008). The need to participate in the international arena has left these governments with little choice but to introduce reforms that are up to speed with the international developments. These reforms have covered most of the areas of the countries' operations and of particular interest to us, the health sector.

The health sector is a major player in the international business arena. Medicine developed in Switzerland is reproduced generically in India and used for treatment in Kenya. Similarly, medical doctors trained in Kenya are practicing in Botswana and others setting up hospitals in the United States of America. This comes to show the level of interdependence in the health sector world wide. However, this interdependence brings about its own demerits. The health sector is sensitive and much regulation is required to ensure the over all wellbeing of the population. Unscrupulous and dubious dealers in this sector can have an everlasting negative effect on the recipients of this medicine.

A good example of this is the death of ten children and the accidental paralysis of 164 others from a tainted batch of a polio vaccine administered in the USA in 1955. This disaster came

about when Cutter Laboratories failed to completely inactivate the virus in their vaccine and as a result 120,000 children were inadvertently injected with live dangerous poliovirus; 40,000 developed mild polio; 164 permanently paralysed and ten killed. Thus the regulation of the international health sector became a major need the world over.

These regulations however, have not been limited to the administration of health products and services only but also in the business of health. The fact that the health sector is greatly interdependent world over has brought about the need for global health standards. Thus we have the creation and implementation of the international Health Management Practices.

Kenya has been on the forefront of implementing policies that allow for greater development in the different facets of its economy. This has been achieved through the liberalization of its markets and the move towards privatization. Public policy issues often relate to international trade, investment and finance. Today, any country's economic policies must consider the foreign sector. These policies are directly concerned with structuring business–to-government and business-to-business relationships in ways consistent with national interests (Grosse and Kujawa, 1992). Kerrets (2008) notes that globalization, liberalization and deregulation have led to sustained pressure from citizenry for better services from the public sector enterprises, thereby forcing governments to initiate public sector reforms. This has greatly affected the public sector especially the health sector and the running of public institutions like parastatals (Kibor, 2008).

Kenya faces a major challenge in improving the health status of its population. Poverty contributes to the poor health status of the population, as the poor constitute more than half of the population in Kenya with women being the majority of the poor (Interim Poverty Reduction Paper 2000 – 2003) this problem is further aggravated by continued high child infant mortality levels, high birth rate and increasing re-emergence of diseases, particularly tuberculosis and HIV/AIDS which has a prevalence of 6.7 % (Household health expenditure and utilization survey report, 2003) The Government of Kenya has noted that health care management plays a vital role in the process of economic growth and development through its products, service delivery and employment creation (GOK, 2004).

Today, most healthcare organizations have increasingly employed modern quality management tools and techniques in efforts of achieving better service delivery to their customers (Weiler, 2004). The private health sector has been at the forefront of adopting and implementing international health management practices, however this sector majorly caters for the upper and

middle class. Hence, the lower class, which has a majority in the Kenyan population, has been minimally affected by these developments.

The Government of Kenya, however has taken note that for it to achieve its health sector reforms, it needs to introduce health management practices that are in line with international standards. The World Health Organisation (2003) noted that health care organizations are very complex and their structures, processes and management have become increasingly significant to the improvement of health care. In this light the Government of Kenya has introduced two major international health management practices through the National Hospital Insurance Fund.
These International health management practices are Capitation and Fee-for-Service. These have majorly been used and are still in use in the USA. The Government of Kenya has adopted them to be used in the administration of Out-Patient services provided by National Hospital Insurance Fund.
The first concept is the Capitation method. This is a health management practice where the health care facilities (hospitals and clinics) are given a specific amount of money by the sponsor to provide health care to the sponsor's clients for a specified period of time (NHIF, 2009). In this case, the sponsor is the Government of Kenya through NHIF and the clients to this scheme are the citizen of Kenya. The citizens will have unlimited access to the healthcare facilities and services for the specified period under which the health provider and the government have agreed in the contract.

The advantage of this management practice is that it transfers the economic risk from the sponsor, which in our case is the Government of Kenya, to the health provider. The reason why this is of benefit to the government is that it has many other obligations in the different sectors of the countries economy, hence it is of advantage to reduce the risk that comes with insuring a country wide population by sharing this risk with other health providers within the country. How this functions is that it frees resources from one sector to be utilized in another sector. It is the same way the government, in the 2010 budget, proposed to out source its transport needs from independent car hire firms so as to free up the capital held in assets in the form of vehicles for its workers.

In Capitation the health provider benefits financially when the citizens do not need any health services or if they do its minimal because then the health provider will not use any financial resources. More to this the health provider is not required to return the unutilized money to the government. On the other hand if the citizens require large quantities of health care, then the health provider is obliged to provide to them irrespective of whether the specified amount given by the government to them is exhausted or not. This means that the health provider would have to dig into its financial resources to be able to meet the health needs of these citizens. Hence the health providers make a proactive move on preventive health care by educating the citizens on how to live healthier lives, which in turn translates to greater health for the nation.

The main disadvantage of this health management practice is that the health providers will tend to provide minimal health care to the clients so as to increase their margins. This means that they will reduce the number of services they offer to each patients and also reduce the amount of time taken on each patients. However, the government plans to stem this by increasing competition in the sector by licensing more hospitals and clinic to offer this service. The competition will ensure that a health provider will strive to provide the best services possible according to the viability of their financial obligation. This will ensure that they get a sizable chunk of patients and retain them who would have otherwise gone to the competition.

The second concept is Fee-for-service (FFS). This is a health management practice where each client is allocated a specific amount of money for a specific period by the sponsor. Just like in capitation, the sponsor here is the Government of Kenya and the client here is its citizens. In this practice, the health facility is paid by the government in accordance to the number of services performed on the citizen assumed to be the patient. The amount paid is deducted from the amount allocated to each citizen for the specified period, and once the citizen exhausts his/her allocated amount, then he/she has to pay for self.

Unlike in Capitation, the risk here is retained by the government but the amount spend on health care is pegged on the services already offered to its citizens and not estimates of services yet to be offered. The advantage of this practice is that it gives the citizen a greater chance of getting all the required services from the health facility because each service performed is paid for either by the government or by the citizen.

The main disadvantage of this practice is that the health providers will try to provide as many services as they possibly can because this will increase their amount of money they will be paid per patient. This means that they are able to give services that are deemed unnecessary for the type of disease or issue at hand. An example is where a health facility performs as many tests as they possibly can on a patient whereas a few tests would have sufficed to diagnose a disease. The other area prone to abuse is that the health providers could increase the amount of consultations they perform per patient. Not withstanding the probable result is that they would decrease the amount of consultation time so as to be able to serve as many patients in a short period of time.

Due to this, the government through NHIF has put a cap on the amount of money that a patient can spend hence the patients will also be able to use the health services on offer sparingly for when the amount allocated to each exhausts, they start paying from their pockets. Another measure the government is taking is by training NHIF staff on surveillance methods and skills so that they can be deployed to the various health providers and monitor the activities of the facilities to ensure that there is no abuse and that each patients is given the right treatment of the issue at hand. Currently NHIF has such Quality Assurance officers who monitor the activities of the hospitals in providing the in-patient services but there is the need to increase and retrain this number so as to be able to handle the out-patient service also.

These health management practices may have their advantages and disadvantages but of great importance is that they are necessary for the development of the health sector in Kenya. Whereas the citizens of Kenya have received these developments with much delight, there have been a few hitches affecting the adaptability of these health management practices.

Rad (2005) notes that the barriers to successful implementation of TQM in health care management includes lack of senior management commitment and involvement, instability of senior managers, inability to change organizational culture towards quality changes and inflexibility of the organization toward environmental and technological change. Others include incorrect planning, lack of continuous education and training for employees and managers, inadequate knowledge or understanding of TQM philosophy, poor team work and participation, inappropriate evaluation of team work, poor accessibility to data and organizational performance, and lack of attention to the needs of internal and external customers.

The factors that affect the adoption and implementation of externally generated management practices are both country and industry specific. The unique nature of each country's economy and other factors found in its culture determine a lot about the adaptability process. Hence we are not able to uniformly assign the factors across the countries or their various sectors of economy. For each sector we have to find the unique riding factors.

The major area of concern in our case is the health sector. This sector ahs its unique need when it comes to the introduction and adaptation of new ideas. In the past we have seen a number of issues come up as was the case in rural Nyanza when mosquito nets were introduced as a measure to curb malaria. The recipients of these nets decided to use them for other purposes as they believed that the box like shape of the mosquito net symbolized a coffin and thus it would bring bad omen on them if they slept under these nets. Thus this shows us just how unique factors of adaptability can be to each sector of the economy and hence our research.

This research aims to outline the factors that are affecting the adaptability of the International Health Management Practices by National Hospital Insurance Fund.

1.1.2 National Hospital Insurance Fund

The National Hospital Insurance Fund (NHIF) is a government parastatal body that is mandated with providing affordable and accessible health insurance cover to the citizens of Kenya. It exists through an Act of Parliament and is managed by a management board. The management board consists of the Permanent Secretary Ministry of Medical Services, the Permanent Secretary Treasury, the Director of Medical Services, Christian Health Association of Kenya, Association of Kenya Insurers, Kenya National Union of Teachers, Federation of Kenya Employers, Non-Governmental Organization, Kenya National Farmers Union, Kenya Medical Association, Central Organisation of Trade Unions, the Inspector General of State Corporations and the Chief Executive Officer NHIF.

The Act attempts to promote all-inclusiveness and participation of all sections of society in the management of the fund and allows contributions to the fund from both persons who are in salaried employment as well as those whose income is derived from the informal sector (Hakijamii Trust, 2007). According to the NHIF Act of 1998, it is mandatory for everyone who is employed in Kenya, is over 18 years of age and earns more than a thousand shillings per month to be a member of NHIF. This is the category referred to as formal sector.

The mission of NHIF as stated in its customer service chatter is to provide accessible, affordable, sustainable and quality social health insurance through effective utilization of resources to the satisfaction of stakeholders.

The National Hospital Insurance Fund (NHIF) was established on 12th July 1966 by Cap 255 after the recommendations of the sessional paper no. 10 of 1965: African Socialism and its application to planning in Kenya. Its establishment was a means to fill the financing gap created after the abolition of the Kshs 5/= mandatory fee for outpatient services in 1965. NHIF was run by an advisory council and it existed as a department of the Ministry of Health (MOH), until Cap 255 was repealed and replaced by the NHIF Act no.9 of 1998 which established it as an autonomous State Corporation managed by the NHIF management board.

NHIF has grown into a membership base of two million contributors and about 6 million dependants. This number includes salaried and self-employed people, with the formal sector spread across 41,000 employers. Currently NHIF collects KShs 4.7 billion every year, 48 per cent of this money is used to pay medical claims while 22 per cent is invested. These members can access health care through 406 accredited hospitals countrywide. Furthermore NHIF has managed to reduce its operational expenses from 80 per cent of total collection in 1998 to 30 per cent by 2007 (NHIF, 2009).

The Fund has steadily grown its revenue from Kshs 2.7 Billion in the financial year 2003 - 2004 to Kshs 4.2 Billion by June 2008. On the same length the benefit payout have also grown by 300 per cent during the same period from Kshs 713 Million to Kshs 2.1 Billion by June 2008. This has mainly been due to increased awareness, an increase in benefit package payout and a simplified claiming process.

Another reason why NHIF has recorded this tremendous growth is due to improvement in its service delivery. In 2002 the Fund revised upwards the benefits to allow for its members a 40 per cent rebate increment so that they can be covered in higher cost accredited hospitals. In 2003 and 2004 NHIF reduced its claims processing time from 90 days to 18 days. Congruently the Fund also enhanced the benefit package to members by establishing a comprehensive in-patient package and extending coverage to include consultation and diagnostic services.

A major milestone in the growth of NHIF has been its insistence on the informal sector and low-income earners. In most countries, commercial insurers have largely stayed away from the low-

income market, mainly because they consider the low income groups not viable sources of insurance business due to high transaction costs, moral hazard, adverse selection, fraud, low retention, lack of quality data and un-sustainability of the group. Low-income persons are vulnerable to risks, but so far NHIF has been accessible to a large number especially through organised groups (Kanenje, 2009).

The importance of properly managed health care provision by NHIF cannot be over emphasized. The lives of approximately 8 million members are depending on it (NHIF website and strategic plan 2005-2010). As the only health insurance that is a parastatal body, NHIF is charged with the responsibility of advising the government on national health policies through regular liaisons and consultation with the Ministry of Health. Through prudent management and investment policies and programs, NHIF is required to protect interests of stake holders (NHIF strategic plan 2005 – 2010 and NHIF customer service charter).

The Fund has a mandate to register and receive all contributions and other payments, set criteria for the declaration of hospitals and to accredit them, make payments out of the Fund to declared hospitals, regulate contributions payable to the Fund, the benefits and other payments made out of the Fund and to protect the interest of contributors.

NHIF faces competition from other health insurance providers. Although it is compulsory for formally employed persons to join NHIF, the informal sector can join only under voluntary basis. The drive to acquire clients from the informal sector has met stiff competition from the private insurers who offer both in-patient and out-patient covers and also segmented the market. African Air Rescue (AAR) is a market leader in this sector (Kibor, 2008).

The fund's relationship with hospitals is categorized on the basis of services to members with the first category of government hospitals eliciting comprehensive cover including maternity and surgery for beneficiaries while the category of mission and private hospitals attracts comprehensive cover except surgery on which there is cost sharing. In the last category of private hospitals, the Fund pays specified daily benefits of between Kshs. 800 to Kshs. 2400 per day.

IPAR (2005) identified challenges for the fund as including management obstacles, inefficient ways of collecting dues, fraud and abuse, limited coverage, poor quality service delivery and unresponsiveness to members needs. Moreover, poor infrastructure and inaccessibility of NHIF

offices especially in the rural areas made it difficult to access the Fund's services (Hakijamii Trust, 2007).

Since its inception, NHIF only offered cover for in-patient services, but with this growth the management decided to introduce the out-patient cover. This is being administered through two international health management models namely the 'Fee-For-Service' and 'Capitation' methods.

1.2 Statement of the problem

Threat to survival created by growing competition in both the private and public sectors has seen the introduction of incentives in order to improve market share in the service industry (Gitobu, 2006). Though not necessarily considered as incentives, NHIF has been keen to introduce different products into its operations, aimed at improving and retaining its market share in the increasingly competitive health insurance industry. Today's environment demands institutions that are extremely flexible and adaptable. Organizations globally now seek to actively differentiate themselves from their competitors in terms of quality of service, flexibility, customization, innovation and rapid response (Ghalayani and Noble, 1996).

The National Hospital Insurance Fund has since its transformation from a department of the Ministry of Health to a state corporation in 1998 implemented various programs and initiatives (Kibor, 2008). A notable initiative is the stream lining of its services to allow for greater efficiency in service delivery. Another notable program has been the move from manual registration and administration of the contributors to an automated system connecting all the branch offices to the head office and to each other. This has allowed greater access of information from any part of the country and a better monitoring of branch level activities by the head office hence accountability and effective performance measurement. There has also been the move to expand the branch network to more parts of the country hence creating a greater reach to the contributors.

NHIF has also improved its reach by introducing different levels of covers to the hospital. Currently, NHIF has three different contracts with hospitals. Contract A is signed with government hospitals and stipulates that NHIF will pay the full in-patient bill for a fully paid up member who uses the services of the hospital. Contract b is made with private hospitals and in this category we mostly find the missionary hospitals. This contract states that NHIF will pay the full in-patient bill except in cases where there is surgery, in such a case the contributor will pay

for the surgery fee. The third contract is aimed at the high cost private hospitals. In this contract NHIF pays a pre-calculated daily rebate to the hospital for each day that the patient is in hospital. In principle, NHIF purposes to cover both in-patient and out-patient medical conditions. However, in practice, only inpatients are catered for. From the feedback of the members, there is high need to include outpatient services in the cover (Kanenje, 2009).

Currently, NHIF is in the process of introducing an Out-patient cover to its members. This cover will be administered through two international health management practices namely capitation and fee-for-services. The introduction of these practices has riding factors that will determine how well it is inculcated into the Funds activities. These factors are a big determinant of how well these practices will be adopted, what resources they will use and how much time it will take to fully adapt.

The purpose of this study was to determine the factors affecting the adaptability of International Health Management Practices by NHIF in Kenya. A review of literature revealed studies that limit focus to the strategic responses of international reproductive health NGOs operating in Kenya to changes in the environment (Mueke, 2006), factors influencing the internationalization process of Kenyan firms (Waudo, 2006) and factors influencing the adoption process in an employer driven social marketing campaign at the International Committee of the Red Cross (Mwangi, 2005).There was no study on the factors affecting the adaptability of International Health Management Practices in Kenya with a specific reference to the NHIF. This study attempted to fill that void.

1.3 The research objectives

This research has a general objective covering a wide angle of the context of the research and also three specific objectives detailing particular areas of interest.

1.3.1 General objective

The general objective of this case study was to determine the factors affecting the adaptability of international health management practices by NHIF. These international health management practices are namely Capitation and Fee-For-Service and are being used to administer the out-patient cover by NHIF.

1.3.2 Specific objectives

There were three specific objectives in this case study, these were:

i. To establish the extent to which the NHIF management and workers have understood the international health management practices Capitation and Fee-For-Service.
ii. To establish the perception of the NHIF management and workers regarding the uptake of these international health management practices.
iii. To identify the specific factors that the management and workers of NHIF are facing as regards the uptake of international health management practices.

1.4 Importance of the study

The benefits of this study accrue to various publics. One of these publics is the policy makers. The results of this study will provide the policy makers with pertinent information as to the factors that affect the uptake and assimilation of international health management practices into the management of the health sector in Kenya. This study will bring information to policy makers at MoH and NHIF management board on important specific factors that will affect the extent of the adaptation of international health management practices.

Another beneficiary to this study will be the general public. This study will bring about better relations between the general public and NHIF as it will bring out the issues that are affecting the adoption of these international health management practices which eventually trickles down to the quality and effectiveness of the services offered to the general public by NHIF.

The academia will also benefit from the findings of this study. These findings are expected to provide an insight into and stimulate interest in the subject of the adaptability of international business management practices to the running of local firms.

1.5 Scope of the study

The study was limited to the three NHIF branches that are being used in the piloting project of the out-patient cover administered using the two international health management practices Capitation and Fee-For-Service. These branches are Nairobi Area office, Industrial Area office and Mumias Area office.

CHAPTER TWO: LITERATURE REVIEW

2.1 The International Environment

According to Johanson and Wiedersheim – Paul (1975), the term internationalization usually refers to either the attitude towards foreign activities or to actual carrying out of activities abroad.

Internationalization has been defined as the process of increasing involvement in international operations, which requires adapting the firm's strategy, resources, structure and organization to international environments (Welch and Luostarinen, 1988; Calof and beamish, 1995).

Johnson and Scholes (2002) state that the survival and success of organizations are influenced by their ability to respond to the following competing pressures. First are changes in the business environment; second, the strategic capability of an organization – its resources and competencies; third, the cultural and political context- the expectations and purposes.

All organizations are an open system. They do not only depend on the environment for their provision of inputs and the disposal of their output to the same, but that they are part of the environment and an integral one for that matter. Thus, for an organization to achieve its objective and ultimately success, realistic approaches that are considerate of the environment must be taken into account (Rue and Holland, 1996).

It is generally accepted in the business environment to talk about the constancy of change, and that the old certainties of planned growth, predictable sales and stable markets no longer exist (Morris and Brian, 1996) Even businesses that focus primarily, or even exclusively, upon the domestic market must be internationally competitive in order to secure long-term survival and growth (Karagozoglou and Lindell, 1996).

In line with this issue of the international environment is the concept of globalization. Globalization according to Hill (2004) refers to shift towards a more integrated and interdependent world economy. Globalization has several different facets including the globalization of markets and globalization of production. It is the world economy which we think of as being globalised. It means that the whole of the world is increasingly behaving as though it were part of a single market, with interdependent production, consuming similar goods, and responding to the same impulses. Globalization is manifested in the growth of world trade as a

proportion output (the rate of world imports to gross world products (GWP) has grown from some 7% in 1938 to about 10% in 1970 to over 18% in 1996). It is reflected in the explosion of foreign direct investment (FDI). FDI in developing countries has increased form $ 2.2 billion in 1970 to $ 154 billion in 1997. This has also resulted in national capital markets becoming increasingly integrated, to the point where some $1.3 trillion per day crosses the foreign exchange markets of the world, of which less than 2% is directly attributable to trade sanctions (Williamson, 1998).

Kiplimo (2008) states that globalization has caused dramatic changes to business practices around the world. It is a process where countries are moving away from a world were national economies are relatively self-contained entities isolated from each other by barriers to cross-border trade and investment; by distance, time, zones and language; and by national differences in government regulations, culture and business systems. We are moving towards a world in which barriers to cross-border trade and investment are tumbling; perceived distance is shrinking due to advances in transportation and telecommunication technology; material culture is starting to look similar the world over; and national economies are merging into an interdependent global economic system.

While they cannot be measured with the same ease, some other features of globalization are perhaps even more interesting. An increasing share of consumption consists of good that are available from the same companies almost anywhere in the world. The technology that is used to produce these goods is increasingly standardized and invariant to the location of production. Above all, ideas have increasingly become the common property of the whole of humanity (Chebett, 2008).

Kiplimo (2008) further goes on to state that the move towards a wider global economy has been driven and strengthened by the widespread adoption of liberal economic policies by the countries. The countries in keeping with the normative prescription of liberal economic ideology are privatizing state owned businesses, adopting widespread deregulation, opening markets to competition and increased commitment to removing barriers to cross border trade and investment, thus building powerful market oriented economies. The trends therefore indicate that the world is moving rapidly towards an economic system that is more favourable for the practice of international trade hence globalization. The last quarter century has seen rapid changes in the

global economy. Barriers to free flow of goods, services and capital have been coming down. The volume of cross-border trade and investment has been growing rapidly than global output, indicating that national economies are becoming more closely integrated into a single interdependent global economic system.

2.2 Health Management Practices

The nature of health care financing systems varies widely across developed countries. With the exception of the United States and South Africa, all of the developed countries have implemented some kind of national health insurance system; that is, they have established programs to ensure that the majority of their citizens have access to health care services with minimal cost-sharing. Some countries (such as Germany and France) require employers to offer and employees to purchase a health insurance plan with payroll taxes as the major source of funding for this. In other countries, such as Canada, general tax revenues supply the major source of funding for their health insurance systems.

2.2.1 Health Insurance

Health insurance is a risk sharing mechanism that lowers the out-of-pocket (OOP) price for medical care at the time of purchase by smoothing medical payments across individuals and time (Barr, 1992). Social health insurances increases equity in the provision of health services by improving access for some groups in the population and widening coverage by bringing additional resources into the health sector (Normand and Weber, 1994).

For most developing countries, the concept of social health insurance works better. Social health insurance is seen as a concept where the rich support the poor in the society as appertains health care. For this to occur, the rich relatively remit more money into the social health insurance fund as compared to the poor. This is mainly achieved through a graduating scale that is used to make deductions according to the salary earned.

However, even if the potential benefit of health insurance is seen, there is no utility in insurance if informal sector workers have no geographical access to health facilities that are accredited by a health insurance (Carrin, 2003). Carrin (2003) further goes on to state that the non-availability of quality health care services (including lack of drugs and other quality deficits) negatively affects demand for health insurance.

On the same breath, simple market solutions, as are common in other sectors of the economy do not work well in the health sector owing to a number of types of market failures. The majority sources of market failures in the health services are the monopoly power of providers, ignorance and uncertainty among consumes, and an element of externality (Normand and Weber, 1994). In order to protect the public and counter market failure, social health insurance is necessary (Kanenje, 2009).

The main categories of funding for health services are government financing through tax, social insurance, private actuarial insurance and direct payment of services by patients. Systems of health financing such as insurances provide an element of mutual support with those at higher risk low incomes supported in part by those in high incomes and low risks (Brown and Churchill, 2000).

One of the greatest challenges for low-income and mid-income countries that have introduced or are in the process of expanding social health insurance is integration of the expanding informal sector and inclusion of the poor (Jhabvala, 1998). As to whether a household demands and is willing to buy insurance , however, depends on the perceived difference between the level of expected utility with insurance and expected utility without insurance (Kirigia et al., 2005).

2.2.2 Capitation

Capitation is an international health management practice, and one of the practices that the government of Kenya is adapting through NHIF in a bid to improve health care in the country. We can define it as a fixed prepayment, per patient covered, to a healthcare provider to deliver medical services to a particular group of patients. The payment is the same no matter how many services or what type of services each patient actually gets. Under capitation, the provider is financially responsible (Public Broadcasting Service, 2005). We can also refer to it as a fixed "per capita" amount that is paid to a hospital, clinic or doctor for each person served.

In the United States health care system, Capitation refers to a method of paying health care service providers (e.g., doctors). Generally these providers are contracted with a type of HMO (Health Management Organisation) known as an independent practice association (IPA). The HMO contracts with the providers to have the latter take care of patients enrolled in the HMO. Most often, payment for such a service is under the capitation system.

Under a capitation system, healthcare service providers (physicians) are paid a set amount for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per period of time.

The amount of remuneration is based on the average expected health care utilization of that patient (there is more remuneration for patients with significant medical history). Other factors considered include age, race, sex, type of employment, and geographical location, as these factors typically influence the cost of providing care.

The down side of capitation is that since capitation does not reimburse physicians any more for taking care of their patients, and visits and procedures cost money, the contracting physicians essentially lose money for each visit or procedure. This situation incentivizes the physicians to reduce the effort spent on each patient, which may result in an overall reduction of time spent on each patient, which is just the case in most private practice. The corollary practices are to under-prescribe, under-diagnose and under-treat patients to reduce costs, and therefore maximize net profit. Another issue to the under giving of the health services is because physicians cannot ethically refuse to see a patient on the basis of the capitation payment schedule. The upside however is that health providers who work under these plans focus on preventive health care as they will be financially rewarded more to keep a person from becoming ill than to treat them once they have become so.

The financial risks the health providers accept in capitation are traditional insurance risks. Since providers have fixed revenues, each enrolled patient makes his/her claims against the full resources of the provider (the value of the capitation). Providers, in exchange for a fixed payment per enrolled client, agree to provide the unknown future benefits and to absorb the costs associated with clinical care. This shift means that the providers become the enrolled client's insurers, resolving claims for care in face-to-face interactions, at the point of care. Hence, capitation places health care providers in the role of micro-health insurers, assuming the responsibility for managing the unknown future health care costs of their patients.

Large providers often have the resources and scale to manage such risks better than smaller providers, in the sense of predicting costs, saving excess money and securing loans, than small

insurers. Small providers, like individual consumers, tend to have annual costs that fluctuate far more than larger insurers as a percentage of their annual cash flow.

Physicians and other healthcare providers generally do not have expertise in the field of finance, liquidity, and insurance and thus suffer from a comparative disadvantage in relation to insurance companies. Because of the greater risks that small providers bear, they can only remain competitive by receiving more fees through capitation. This translates to the fact that HMOs use this as a good reason not to contract with providers who require more remuneration.

2.2.3 Fee-For-Service

Fee-For-Service (FFS) is the other health management practice that the government of Kenya is adapting in the quest to improve health care in the country. We can define FFS as the traditional method of reimbursing physicians, hospitals and other health care providers for each service performed per visit. The fees increase as more services are provided or as more expensive services are substituted for less expensive ones.

To further understand it, we can say that fee-for-service occurs when doctors and other health care providers receive a fee for each service provided such as an office visit, test, procedure, or other health care service. Fee-for-service health insurance plans typically allow patients to obtain care from doctors or hospitals of their choosing, but in return for this flexibility they may pay higher co-payments or deductibles. Patients frequently pay providers directly for services, and then submit claims to their insurance company for reimbursementhttp://en.wikipedia.org/wiki/Fee-for-service - cite_note-IW-1#cite_note-IW-1. However the Government of Kenya has adopted it in a way that the patient is given a choice of various hospitals from where to benefit but does not pay the fee. Rather, the services offered are paid for by the insurance provider, which in this case is the NHIF.

Under the fee-for-service method of payment, health care providers receive a fee (or payment) for each service they provide. The actual medical service is the unit of payment and there is some discretion regarding what constitutes a medical service. A service unit can be very distinct (i.e., urinalysis test) or relatively comprehensive (i.e., an appendectomy where the physician payment covers all care associated with the procedure including the preoperative visit, the surgical

procedure itself, and some follow-up care). Thus, the service for which payment is made can actually be several separate, discrete services.

Fee-for-service payments to the health care providers are based on charges that are either set by professionals or by third-party fee schedules. A fee schedule defines the maximum acceptable charge for medical services. In the United States of America, one of the most widely used schedules is the *Medicare Fee Schedule*, which was developed by the Medicare program to pay health care providers for care used by Medicare beneficiaries.

2.3 The Kenyan Environment

Kamau (2008) states that the challenge to national economies remains on how to capitalize the opportunities for growth and development afforded by globalization, while at the same time minimizing the risks. In an obvious sense, this means following appropriate policies: stable macroeconomic policies, prudent financial policies and sound regulatory policies. But the appropriate policies are easier to describe than to implement. Their specifics are likely to vary over time. The more fundamental problem is thus how to develop institutions with the capacity to determine appropriate policies, implement them and stick to them until circumstances change.

In Kenya today and the world over, businesses have found themselves in a more competitive environment. Organizations are dealing with a more informed consumer whose source of information is only a finger tip away- the internet; consumer taste and preferences are becoming more advanced and movement of capital plus other factors of production is freer and at reduced costs. The result is a pressurized organization that has to change its operations, products and service offerings to suit the changing demand.

Kenya’s development policies and strategies hinge on rapid economic growth and development, which is reflected in the general improvement of the population’s standard of living. Kenya as a country is committed to becoming a Newly Industrialized Country (NIC) by the year 2020. the achievement if this requires; political and macroeconomic stability, rapid economic growth and development, as well as increasing market size, outward orientation and elimination of, or reduction in, protective tendencies, high quality infrastructure, competitive production costs and private sector participation (Chebett, 2008).

Access to health care has long been considered as pivotal in helping people acquire core capabilities that permit them to escape poverty. Public health institutions in Kenya are characterized by long queues of patients and are generally inaccessible to the poor. Access to health services by the poor – meaning availability, affordability and physical accessibility of drugs and consultation services – has been limited owing to factors ranging from cost sharing to long distances to health facilities (Kipra, 2002).

The health sector like any other sector in Kenya has experienced hard times in the last decade or so. This is mainly due to hard economic times facing the country and other forces such as change in technology, liberalization, expectations of patients, rising levels of poverty, poor infrastructure e.t.c. all these have made it hard and every expensive to deliver health care in the country (Kundu, 2008).

Kundu (2008) further goes on to state that the health sector in Kenya is today faced with unprecedented rivalry and competition among various players. In the past, the health services provided by the public service were perceived as being of lower quality compared to mission and private health providers. This is no longer the case. The public service have significantly improved with the consequence of both patients and qualified service providers streaming back to the public health institutions. The government of Kenya caters for 60% of health care delivery while 40% is shared between the church owned health facilities and the private health units (MOH NHSSP II, 2010).

Chebett (2008) states that business process re-engineering is done to eliminate wastage and improve on efficiency in production by paying attention to the internal structures and systems. A number of firms have undertaken this process in order to be in a better position to face the global competition. Leading firms are investing the latest affordable information technology in manufacturing; KBL has implemented computerized bottling system while BAT has introduced its intelligent packaging system. Kenya airways has also undertaken automation of business processes to enhance efficiency.

This move by the government to introduce the Out-patient services administered through FFS and Capitation methods has a direct effect on the amount of money required to finance the whole process. The out-patient service is expected to require a bigger amount of money than the in-patient service as the majority of health services in the country occur here. This new scheme is

expected to cost NHIF KShs nine billion per year. With no known external funding, it means that the contributions currently made to NHIF are expected to rise by 600 percent.

Currently, the highest amount that any contributor pays is KShs 320. This is for those earning KShs. 15,000 and above. However, with the introduction of this new health plan, the contributions will rise to KShs. 2,000 a month for those contributors earning more than KShs 100,000 a month. Those earning between KShs 50,000 a month and KShs 99,999 will make a contribution of KShs 1,500 to NHIF. Those earning between KShs 30,000 and KShs 49,999 will make a contribution of KShs 1000 to NHIF and those earning between KShs 25,000 and 29,999 will make a contribution of KShs 850 to NHIF. On the lower side, the minimum contribution will be KShs 150 for those earning less than KShs 6,000. Those in the informal sector will have the monthly contributions rise form KShs 160 per month to KShs 500 per month. Those who are not employed but would like to become members of NHIF will be able to pay KShs 300 a month.

These new payment are pending gazettement by the minister for Medical Services but have already caused an uproar since their publication in a Kenyan newspaper. The current contributions to NHIF range from KShs 30 to KShs 320 only. Thus for the type of increase in contribution expected, the Government of Kenya will be faced by a number of hurdles and will need to understand the factors that will either make the new health management plan work or fail.

In looking at the introduction if the international health management practices we have to make an assumption that the workers and management of NHIF will also be affected by these new rates and will react from two points of view. The first is that they are workers of NHIF and that the new scheme means different things including increased workload and change in work schedules and job descriptions. The second point of view will be that of Kenyan citizens whose contribution to the Government of Kenya through statutory deductions is being increased by approximately 600 percent. This means that the adaptability of the international health management practices by the management and workers of NHIF will have direct determinants from these points of view and will range from quantitative measurable factors to qualitative immeasurable factors.

David Okwemba in an article in the Sunday Nation June 20th 2010 states that there are many skeptics of the introduction of this new scheme by NHIF. He states that even some of the NHIF board member representatives are yet to be fully convinced of the viability of this health plan. He continues to state that most of the independent players in the health industry think that NHIF is making a terrible mistake by introducing the out-patient cover to be administered through the two international health management practices. Some of the independent health management practitioners cite examples of the countries where these practices have been used and the negative effects they have had in those economies. Most of them give the example of the USA where Capitation is used to administer health insurance and the fact that it has been faulted as a practice that only caters for those who are wealthy. However, the contrast of how Capitation is used in the USA and how it is used in Kenya is that the USA does not have a national health insurance policy thus Capitation is administered by private practitioners. On the other hand, in Kenya we have a national health insurance policy under the NHIF and Capitation will be administered through this hence eliminating a good level of the risk that is associated with private practice.

The government of Kenya through the NHIF board has sought to re-engineer the businesses processes in the health sector and hence its adaptation of the two International Health Management Practices namely Capitation and Fee-For-Service.

CHAPTER THREE: RESEARCH METHODOLOGY.

3.1 Research design

The research used a case study design to determine the factors influencing the adaptation of the two International Health Management Practices by NHIF management and workers. Researcher Robert K.Yin (1984) defines the case study research method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident. The case study emphasizes a detailed contextual analysis of a limited number of events or conditions and their relationships.

In our context, the case study research method was used to determine those factors affecting how well the international health management practices will be adapted by NHIF workers and management as these factors are still not yet empirically determined. This gave a better view of what these factors are and to what extend they are affecting this adaptability process.

3.2 Data collection

Data was collected using a questionnaire administered by the researcher. The questionnaire was administered to the management and workers of NHIF in three of the branches namely Nairobi Area office, Industrial Area office and Mumias Area office. These branches are already being used as the representative sample for the piloting period of the out-patient cover. They were empiricaly determined as a representative sample of all the NHIF branches country wide. The out-patient cover will be administered using two international health management practices namely Capitation and Fee-For-Service.

The questionnaire administered had two parts A and B. Part A was to collect data on the profile of the respondents which included information such as age, gender, number of years worked at NHIF and the department in which the respondent works in among other issues.

The second part, B, collected data addressing the objectives of the study. This contained questions regarding the level of understanding of both Capitation and Fee-For-Service, training towards the understanding of the same, factors affecting this understanding and top management's level of commitment among others.

The questionnaire administered included both close ended and open ended questions. The close ended questions were mainly be used for information that required quantifying and that was later

presented in the quantified form. The open ended questions were used to get qualitative information on the strengths and weaknesses used to build the case study concerning the factors that affect the adaptability of the health management practices.

3.3 Data analysis

The data collected from this case study was analysed using prescriptive statistics such as tables, charts and percentages to represent the response rate and information on the variables under study. The analysis first of all included key demographic information about the workers and management of NHIF gathered from the first part of the questionnaire. It also had the analysed information on the factors that affect the adaptability of the international health management practices.

The quantitative data collected was used to support and provide a better analysis for the qualitative data collected. The qualitative data collected bore a greater significance in the quest to find the effect of the factors researched on the adaptability of the international health management practices hence needed the use of the quantitative data for support during the analysis.

CHAPTER FOUR: DATA ANALYSIS AND FINDINGS

This chapter covers data analysis and findings of the study. Data was collected from 150 workers and management of NHIF in three representative branches. Out of the 150 workers sampled, 147 respondents and this was a reasonably high response rate of 98%.

Descriptive techniques were used to organize and interpret the information. The data is presented in the form of proportions with illustrations in the form of pie charts. It documents factors affecting the adaptability of international health management practices by NHIF in Kenya.

4.1 Respondents' profiles

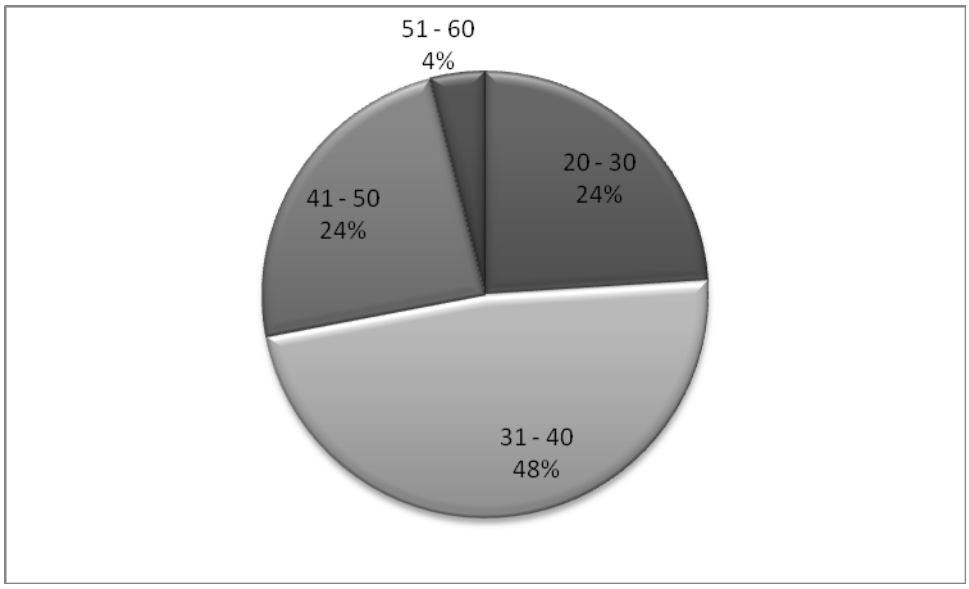
This section presents data on personal characteristics of the respondents, all of whom were workers of NHIF. The characteristics include age, gender and level of education.

4.1.1 Age

The respondents were asked to give their age. Of the sampled respondents 48% were between the ages of 31 to 40 years of age. Those between the ages of 20 to 30 years were at 24% and so were those between the ages of 41 to 50. 4% of those who responded were between the age of 51 to 60 years. The biggest concentration is in the age bracket of 31 to 40 years.

Figure number 1 shows the different age categories and the distribution of NHIF workers among these.

Fig 1: Age

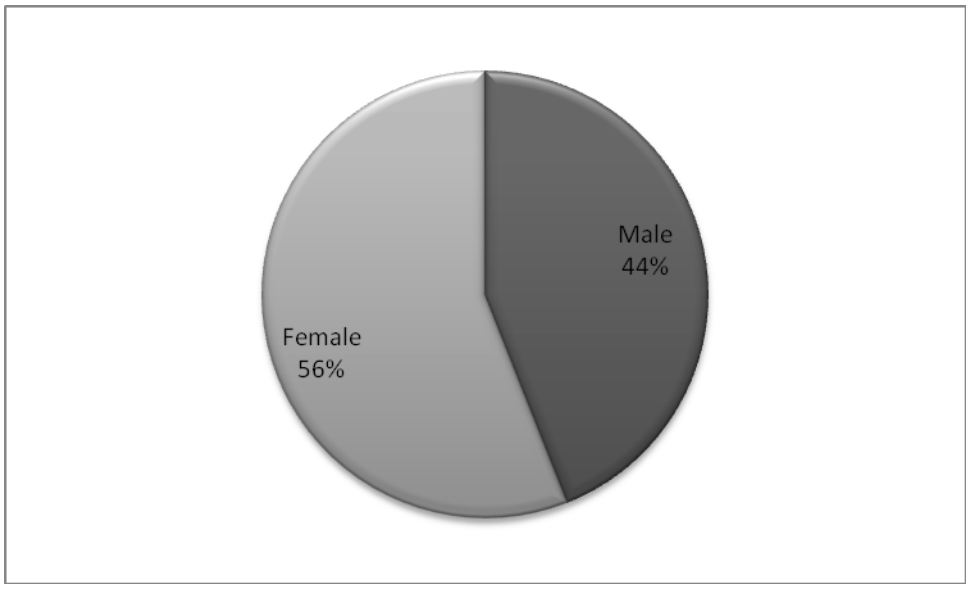


This is a generation that is getting settled in its career and so they pay more careful attention to what is happening in the companies where they work. This is opposed to the age bracket of 21 to 30 where most of them are still on the move and hence do not settle in one company for long. The issue with this age bracket is that they do not push for policy change but rather look for organizations that have policies they can work with. The other age bracket of 31 years and above are already settled and are not as enthusiastic about changes in the company but rather go with what is happening or resist change to a certain level.

4.1.2 Gender

The respondents were asked to indicate their gender. Out of the 147 who were sampled 64 were male and 83 were female. This was a 56% for the ladies and 44% for the men.

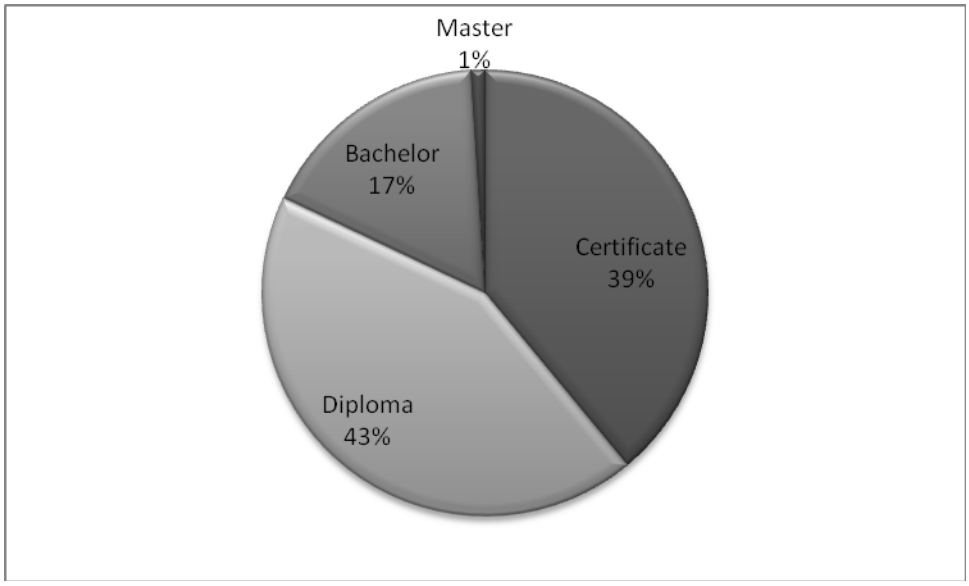
Fig 2: Gender



4.1.3 Academic qualification

The level of academic qualification has a bearing on the understanding of the issues under study. Respondents were asked to indicate their academic qualifications. Of the respondents, 39% were certificate holders, 43% had diplomas in various disciplines, 17% had a bachelor's degree and 1% had a master's degree.

Fig 3: Academic Qualification



Thus most of the respondents had a good academic background and therefore had the right aptitude to understand the issues under study.

4.1.4 Years of service

The respondents were asked to state the number of years they had worked at NHIF. Out of the 147 respondents sampled, 71 of them have worked in NHIF for seven years, this represents a 48% of the population and this was the highest category among those sampled. Of the respondents, 24% had worked in NHIF for four years and this was 35 of those sampled.

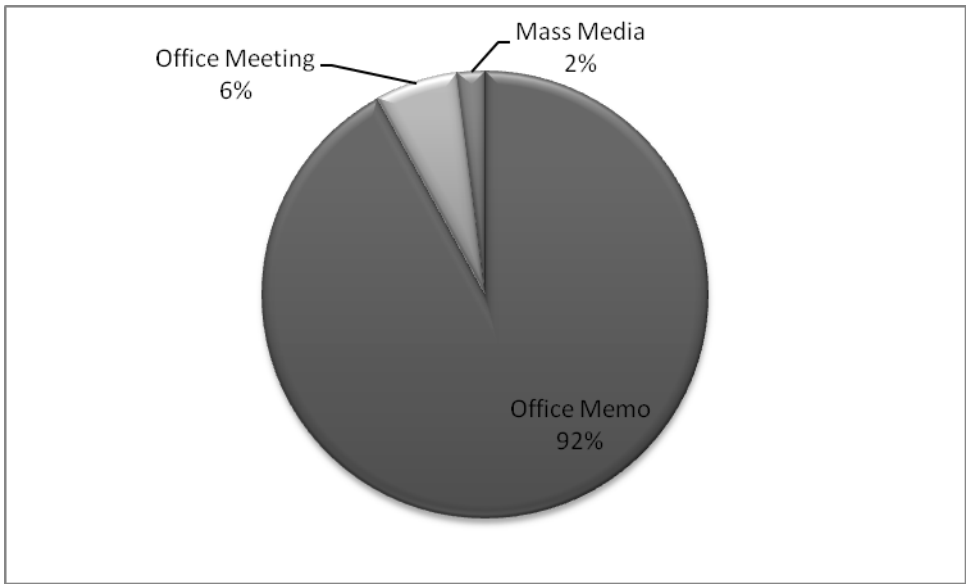
4.2 Department

NHIF has six major departments and these are operations, quality assurance, finance, human resource, IT and security. Of the respondents sampled 90% were in the operations department. This is the department that is concerned with the implementation of the Outpatient service and the adaptation of the two international health management practices.

4.3 Channel of communication

The respondents were asked to state the channel through which they came to learn about the adaptation of the two health management practices namely Capitation and Fee-For-Service. Of the respondents, 92% stated that they learned about the adaptation of these management practices through an office memo. There was a 6% of the respondents who stated that they learned from an office meeting and the other 2% learned about it from the mass media.

Fig 4: Channel of Communication



More than 90% of those interviewed also continued to state that they did not first understand the meaning of the terms by just reading about them in the office memo but rather they understood after the office meeting where they were explained for in a more detailed manner.

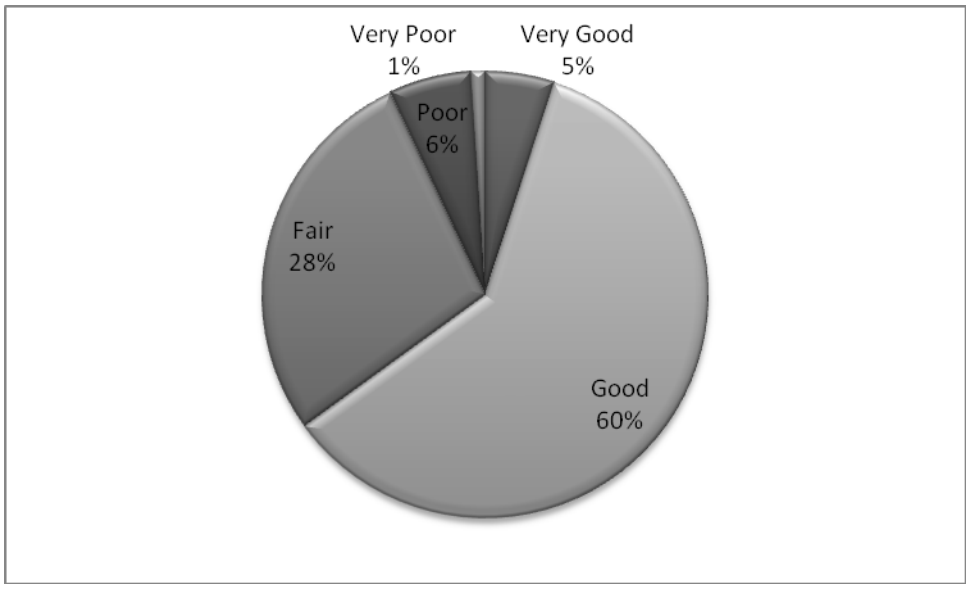
4.4 Capitation and Fee-For-Service

Capitation and Fee-For-Service are the two health management practices that NHIF is adapting to be used in the administration of its Out-patient insurance facility. The respondents were asked about their level of understanding, training needs and the suitability of the two practices.

4.4.1 Level of understanding

The respondents were rated on a five level scale of: very good, good, fair, poor and very poor. Of those who responded, 60% stated that they had a good understanding of the two health management practices of capitation and fee for service. Of these, 28% stated they had a fair understanding, 5% stated that they had a very good understanding, 3% had a poor understanding and 1% had a very poor understanding.

Fig 5: Level of Understanding



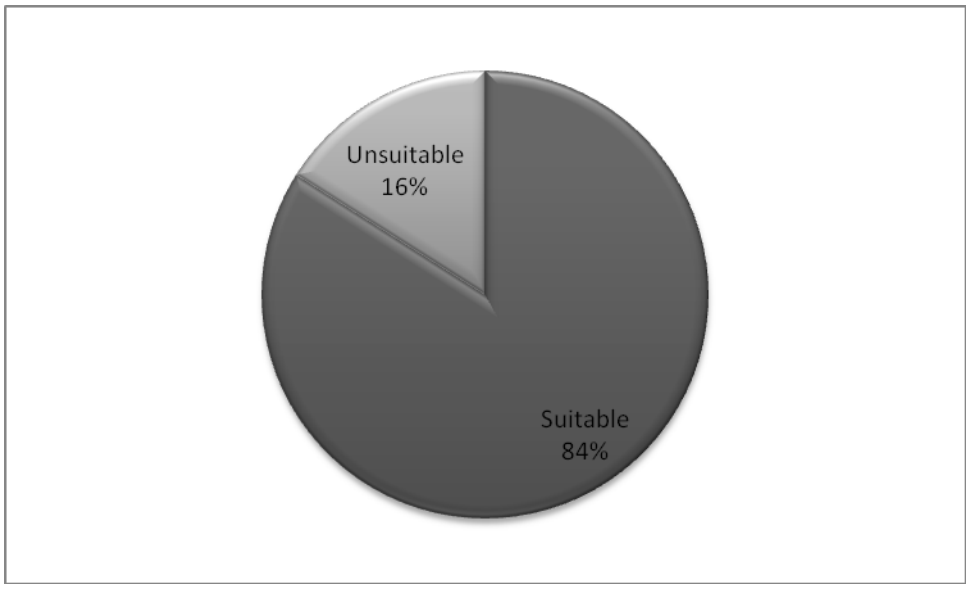
4.4.2 Training

All of the respondents stated that there was a need for more training as to how the two health management process work. They stated that although there was a good level of understanding, the two concepts appeared complex and thus they needed some further training on how the two practices work.

4.4.3 Suitability

Of those sampled, 84% stated that the two health management practice being adapted were suitable in the administration of the Out-patient insurance facility. The other 16% stated that these two methods had a lot of loopholes in them and thus were not suitable to be implemented in Kenya unless they were highly customized to the local situation.

Fig 6: Suitability



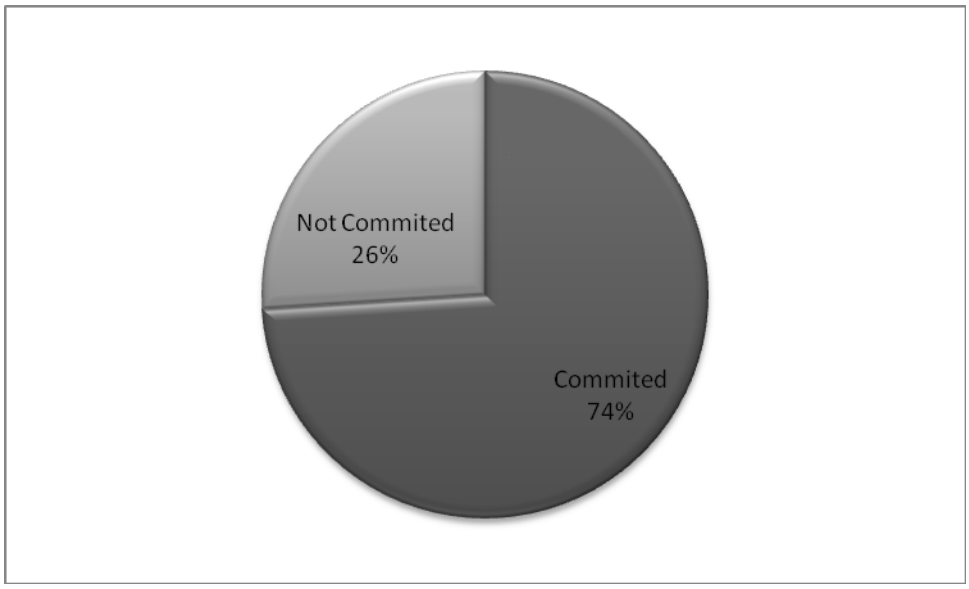
4.4.4 Changes needed

Of the respondents, 98% said that for the new health management practices to work there are a number of changes that need to be effected. One of these changes is to ensure that all public health facilities are well equipped in terms of staff, equipment and medicine. Most of the respondents noted that there is mismanagement of public health facilities and thus to make the adoption of these health management practices effective, better accountability measures have to be put into place.

4.5 Top level management's commitment

Out of those sampled, 74% felt that the top level management was committed to the implementation of the new business model but they also continued to state that there was very little information on the said thus it seemed as though the commitment was waning.

Fig 7: Top level management commitment



4.6 Introduction of new rates

The new rates also affect the workers of NHIF and 82% of those who respondent said that the rates were high. The other 18% felt that the rates were manageable and consumerate with the current market rates for health care.

4.6.1 Current rates

Figure number 8 shows the current rates that NHIF has been using to administer the in-patient medical insurance cover. These rates were effected in 1991 through an Act of Parliament and as recommended by the NHIF board. These rates have not been revised since then, irrespective of the changing cost of health care.

Fig 8: The current rates

Gross Salary	Contribution (Kshs)
1000 – 1499	30
1500 – 1999	40
2000 – 2999	60
3000 – 3999	80
4000 – 4999	100
5000 – 5999	120
6000 – 6999	140
7000 – 7999	160
8000 – 8999	180
9000 – 9999	200
10,000 – 10,999	220
11,000 – 11,999	240
12,000 – 12,999	260
13,000 – 13,999	280
14,000 – 14,999	300
15,000 and above	320

4.6.2 New rates

Figure number 9 shows the new proposed rates that will be required from the members of NHIF as they start benefiting from the introduction of the Out-patient insurance cover to be administered using the two international health management practices.

Fig 9: The new rates

Gross Salary	Contribution (Kshs)
Less than 5,999	150
6,000 – 7,999	300
8,000 – 11,999	400
12,000 – 14, 999	500
15,000 – 19,999	600
20,000 – 24,999	750
25,000 – 29,999	850
30,000 – 49,999	1,000
50,000 – 99,999	1,500
Over 100,000	2000
Self Employed (Special)	500
Indigents (Voluntary)	300

4.7 Other factors affecting adaptability

The other factors that were noted as affecting the adaptability of the international health management practices by NHIF included lack of personnel and hospital connectivity.

4.7.1 Lack of personnel

Among the respondents, 72% of them recommended that NHIF should increase its workforce sighting the reason that the introduction of the Out-patient insurance facility would increase the work load and the current work force was barely enough for the work load. It was noted that there still a number of offices across the country that are still understaffed and thus there was need to increase the workforce so as to meet the demand that would be create by the new developments.

4.7.2 Hospital Connectivity

Of the respondents, 47% stated that the issue of connecting hospitals to the NHIF database was the other issue that would hinder the adaptation of the health management practices. They note that not all hospitals were connected and that meant NHIF members could not access health insurance thought the hospital.

The other issue with connectivity was that the networks supporting the connectivity were not stable and thus there were many delays in trying to process any transaction by the hospitals.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The major purpose of this study was to explore the factors affecting the adaptability of international health management practices by the NHIF in Kenya. This chapter presents the findings of this study in a summary. More to this, the researcher has recommended the way forward and suggestions for future research.

5.2 Summary

From the study, there are a number of factors that influence the adaptation of international health management practices by NHIF in Kenya. These factors were brought up the respondents. The first segment of the interview was to get the demographics of the respondents and this included information about their age, gender and level of education. This section about their profile also included information about their job grades, departments and years in employment at NHIF.

The second part of the questionnaire contained questions about the two international health management practices that NHIF is using to administer the Out-patient health insurance service. This segment contained questions about the level of communication inside of the organization, the level of understanding of the international health management practices, the need for training, the level of commitment by top management and the perception by the workers of NHIF as appertains the new contribution rates.

From the findings, it was noted that the biggest population of NHIF workers were aged between 31 and 40 years. The average length of stay in NHIF for most of the population was seven years. This shows that most of the workers have been employees in other organizations. This translates to them having a good knowledge of how other organizations work and also for them having knowledge of how transitions are treated by other organisations. In the same population, it was noted that most of them were diploma holders and there was also a good number of workers with degrees.

These findings show that the respondents are in a good position to understand the requirements of the adaptation process of the international health management practices and make objective decision, holding other factors constant, about how well the adaptation will be effected.

The study also found that the biggest percentage of the respondents were in the operations department. This is the department that is mandated with the implementation of the international health management practices hence it is better placed to know the factors that affect the same. The research also found that 89% of the respondents were in the middle job grades while 7% were in the support staff and 4% were in the management. Thus the biggest percentage of respondents included those who are mandated to carry out the actual implementation of the international health management practices.

These findings gave a good grounding about the factors that the respondents brought out as affecting the adaptation of the international health management practices.

Communication came out as one of the major factors affecting the adaptability of these practices. It is not just enough to state that the organization is introducing a new business process but that this communication should be made in an effective manner and through a channel of communication that allows for timely feedback. The biggest issue noted was that most of the workers got the communication about the introduction of the health management practices through an office memo and it was in a summarized form. Most of the workers stated that it would have been better if it had been communicated through a channel where there would be a chance for feedback in the form of questions and clarifications.

Another factor that came up was the issue of level of understanding. The communication done about the international health management practices came in words that needed definition and hence it took a longer time for the workers to understand exactly what was being communicated. It also meant that there would also be a problem in the implementation stage of these practices as workers would need a lot of clarification.

Because of the complexity of the international health management practices being introduced, there was need for training. There was training done in the initial stages of the introduction of the new business practices but it did not cover enough ground for the workers to be confident about implementing the practices. Thus the research found that level of training would be another factor that would affect the adaptability of the international health management practices by the workers of NHIF in Kenya.

The level of commitment by top management also came out as another factor affecting the adaptability of the international health management practices. The research found out that most workers perceived the top management as being committed to making the adaptation of these

practices possible and thus it greatly affected the perception of the workers towards the same. Those who said that there was low commitment by top level management stated that this reduced the morale of adapting this system into the daily running of NHIF.

The perception of the new contribution rates by the workers of NHIF was also another factor that affected the adaptability of these international health management practices. All the workers of NHIF, by virtue of being residents of Kenya are liable to contribute to NHIF also. 82% of these respondents felt that the new rates that would be effected as a result of the introduction of the out-patient insurance service to be administered through Capitation and fee-for-service were high.

5.3 Conclusions

From the findings, the researcher concluded that the biggest percentage of the workers of NHIF are well educated and are competent enough to implement international health management practices into the running of NHIF. These workers also have a good work experience and are thus in a good position to borrow experience from past jobs to apply in the implementation of the new business processes.

The researcher also concludes that communication is an important aspect of introducing a new working system to the organization. Communication should be planned with comprehensive information being passed in the right channel of communication. The researcher realized that the level of communication and the understanding of the information being communicated greatly determined how well the workers were determined to adapt the international health management practices.

It was also concluded that training should follow communication. After communicating the need to adapt the new practices, there should be a training to familiarize the workers with how the practices work and how they should be implemented. Most workers stated that there was a difference in knowing about the practices and in trying them out in a forum. Thus NHIF should invest in training programs for its workers as concerns the two international health management practices being introduced.

The researcher also concluded that the top level management should show a satisfactory level of commitment. The top management provides leadership and overall direction, thus it is important

for them to show the willingness and impetus towards the implementation of the international health management practices.

From the research, it was also concluded that NHIF needs to put in place a system to talk with the workers and explain in detail the rationale of coming up with the new rates and also to give them the cost benefit analysis of the same. This will enable the workers get a better picture and eventually change their attitude towards the new rates.

5.4 Recommendations

From the findings and the conclusions, the researcher recommends that NHIF should take into consideration the factors that have been brought forth by its workers as affecting the adaptability of the adaptation of the international health insurance practices.

5.4.1 Communication

The researcher recommends that NHIF come up with a good system of communication between the management and the workers. This system of communication should make it possible for workers to give good and timely feedback and also to get involved in the whole process of implementation.

5.4.2 Training

The researcher recommends that NHIF should put in place a series of training programs that will be used to induct the workers as to the working of the new health management practices. This should be done in graduating phases with each training session covering a particular area of the adaptation process.

5.4.3 Commitment by top level management

There researcher recommends that the top level management show utmost commitment of the implementation of the new international health management practices. The researcher also recommends that the top level management should visit the branch offices and talk to the workers in forums other than communicating through office memo. This will solidify the level of commitment of the top level management.

5.4.4 New rates

The researcher recommends that NHIF applies itself to making sure the workers understand the benefits of the new health management system and how it is that they will get utility for their money with the new developments. NHIF should make sure that the workers are well sold out to the benefits of the new cover as this will determine how well the workers will ensure it is implemented.

5.5 Suggestions for further research

The researcher recommends further research on different ways that local organizations can effectively communicate the introduction of international working systems into the everyday running of the business. The researcher also recommends further study on the ways in which NHIF can fund the new out-patient insurance facility without necessarily further burdening its already existing contributors.

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APPENDICES

APPENDIX 1: AUTHORIZATION LETTER

University of Nairobi

School of Business

TO WHOM IT MAY CONCERN

RE: JACOB MUIA MUTINDA

Through this letter, I wish to confirm that the above named is a bonafide postgraduate student at the School of Business, University of Nairobi.

Further, I wish to inform you that the student is collecting data for his research proposal on **factors affecting the adaptability of international health management practices by the national hospital insurance fund (NHIF) in Kenya.**

Through this letter, I am kindly requesting you to provide the student with any form of support that is required to collect data.

Dr.John Yabs (For)

Chairman, School of Business.

APPENDIX 2: QUESTIONNAIRE

Please tick the appropriate response.

PART A: PROFILE

1. Age

a) 20-30 years ( )

b) 30-40 years ( )

c) 40-50 years ( )

d) 50-60 years ( )

2. Gender: Male ( ) Female ( )

3. What is your level of education?

a) Certificate ( )

b) Diploma ( )

c) Bachelors Degree ( )

d) Master Degree ( )

e) PHD ( )

3. Job Grade (HF)…….

4. Department

a) Operations and Customer Service ( )

b) Finance and Credit Control ( )

c) Quality Assurance ( )

d) Human Resource and Personnel ( )

e) Administration ( )

5. Years of employment at NHIF …….

PART B

6. How did you know about Capitation and Fee-For-Service?

a) Office Memo ( )

b) Office Meeting ( )

c) NHIF staff internet portal ( )

d) Colleague at work ( )

e) The Mass Media ( )

f) Other ( )

If other specify……..

7. To what level is your understanding of Capitation and Fee-For-Service?

a) Very Good ( )

b) Good ( )

c) Fair ( )

d) Poor ( )

e) Very Poor ( )

8. What is your opinion on the introduction Capitation and Fee-For-Service as practices through which the Out-Patient cover will be administered?

a) Very Good initiative ( )

b) Good initiative ( )

c) Fair initiative ( )

d) Poor initiative ( )

e) Very Poor initiative ( )

Give your reasons:

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……..……..

9. Have you been trained on Capitation and Fee-For-Service?

Yes ( ) No ( )

10. Is there need for more training on Capitation and Fee-For-Service?

Yes ( ) No ( )

11. Is Capitation and Fee-For-Service suitable for use in Kenya

Yes ( ) No ( )

Give reasons for your answer:

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…….

12. In your opinion is NHIF able to implement and adapt Capitation and Fee-For-Service into its daily running?

Yes ( ) No ( )

Give reasons for your answer:

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…….

13. In your opinion what does NHIF need to change in order to be able to adapt Capitation and Fee-For-Service effectively?

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…….

14. In your opinion what is the level of the top management commitment to this initiative?

f) Very Good ( )

g) Good ( )

h) Fair ( )

i) Poor ( )

j) Very Poor ( )

15. What is your opinion on the current NHIF contribution rates?

a) Too High ( )

b) High ( )

c) Fair ( )

d) Low ( )

e) Too Low ( )

16. What is your opinion on the new proposed NHIF contribution rates?

a) Too High ( )

b) High ( )

c) Fair ( )

d) Low ( )

e) Too Low ( )

17. In your opinion what do you feel are the factors that affect the adaptability of Capitation and Fee-For-Service by the workers and management of NHIF?

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18. What suggestions would your make to the NHIF management in order to improve the adaptability process of Capitation and Fee-For-Service?

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THANK YOU