EFFECTIVENESS OF MEDICAL SCHEMES ON EMPLOYEE SATISFACTION: A CASE OF POLICE PERSONNEL IN ELDORET WEST SUB-COUNTY, KENYA

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DECLARATION

This research study is my original work and it has not been presented in any university or institution for academic purposes.

Signature…………………………. Date…………………………..

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L50/66104/2013

This research study has been submitted for examination with my approval as the University supervisor.

Signature ------------------------- Date------------------------------
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LECTURER, UNIVERSITY OF NAIROBI

DEDICATION

I dedicate this work to my employer National Hospital Insurance Fund management who gave me this rare opportunity to advance my education and also gave the financial resources to make this study a success. I would also like to dedicate this study to my family and friends for their moral support and encouragement. My greatest gratitude goes to my mother Christina Kipkurgat Soti and my cousin Michael Kipkorir Chirchir whose love, sacrifice and commitment towards giving all of us in our family an education remains unrivalled. Lastly, I dedicate my study to my children Anita and Kigen for challenging me to go back to school.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency Syndrome
BNHS	Bureau of National Health Statistics
CBHF	Community Based Health Financing
CHPS	Community Health and Planning Services
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
IPAR	Institute for Policy Analysis and Research
NGOs	None Governmental Organizations
NCMS	New Cooperative Medical Scheme
NHIF	National Hospital Insurance Fund
NHIS	National Health Insurance Scheme
NPRS	National Poverty Reduction Strategy
OOP	Out of Pocket
PFH	Partners for Health
SPSS	Statistical Package for Social Sciences
SHI	Social Health Insurance
SPSS	Statistical Package for Social Sciences
WHO	World Health Organization

ABSTRACT

The purpose of this study was to assess the effectiveness of medical schemes on employee satisfaction. The study objectives included: establishing the medical schemes' accessibility to employee satisfaction, determining the medical schemes' affordability to employee satisfaction, evaluation of the medical schemes' sustainability to employee satisfaction and establishing the medical schemes' quality of services on employee satisfaction. The study used a descriptive design and employed simple random sampling. The target population for the study was both the regular and the administration police officers in Eldoret West Sub County, who were a total of 585 police officers from which 225 were sampled. Out of these officers, 119 were from the administration police and 106 from the regular police. The researcher interviewed these two groups of police officers and got varied responses on the medical schemes' effectiveness on their satisfaction and how the scheme affects them on carrying out their duties. Questionnaires were used to collect primary data. The study used descriptive and inferential statistics as the main methods of data analysis. The analysis and presentation of data focused on the frequencies, percentages and tables. The study was expected to benefit the police officers, medical scheme providers, government, and scholars. The study found out that the medical scheme is accessible, affordable, and sustainable and offers quality services. However, the study observed that most of the police officers are not satisfied with the medical scheme that has been implemented. This is in terms of the unavailability of drugs in the hospital pharmacy as most of them were noted to have been buying drugs from chemists and pharmacies outside the medical facility upon a prescription. The study concluded that the medical scheme has been successful in ensuring employee satisfaction in that it has managed to cover their healthcare requirements. The medical scheme has also helped employees to pay for their health care needs such as nursing, surgery and medical accommodation. This study recommends that the government needs to ensure that the medical facilities are available throughout the country as it not only ensures employee satisfaction but also enhances easy access to medical services. The study also recommends that there is need to eliminate barriers that exist in accessing the medical facilities.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Over the years, it has been observed that employees play an important role in the sustenance of the developing countries' economies. Their output is dependent on their welfare. Medical schemes play an important role in the health care system of any nation by modifying it to match the country's health care needs. Medical schemes are increasingly recognized as a tool to finance health care provision in developing countries and have the potential to increase utilization and better protect people including the employees against health expenses and address issues of equity WHO, (2000). Health financing systems through general taxation or through the development of medical schemes are generally recognized to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs (Doetinchem, Schramm and Schmidt, 2006). According to the World Health Organization (WHO), personal health payment is the least efficient and most inequitable means of financing health care and prevents people from seeking medical care and may aggravate poverty. Most employees are overburdened by economic obligations and might not be having disposable income to carry out the personal health payment. There is a growing movement, globally and in the African region, to reduce financial barriers to quality medical access generally in the public and private sector, but with particular emphasis on high priority services and vulnerable groups (Witter, 2009).

In Germany in 2009, a uniform contribution rate was set by the government and, although it continued to collect contributions, all contributions were centrally pooled by a new national health fund, which allocated resources to each sickness fund based on an improved risk-adjusted capitation formula. This formula, in addition to age and sex, took morbidity from 80 chronic illnesses into account. Sickness funds received considerably more for patients with cancer,

AIDS or cystic fibrosis than for “ordinary” insured. In 2009, the sickness fund charged an additional nominal premium in the cases where they received insufficient resources (Busse, 2008). Klazinga (2008), states that in Netherlands a mixture of income-related contributions and premiums paid by the insured finances the statutory medical scheme. The income-related contribution is set at 6.5% of annual taxable income. Employers must reimburse their employees for this contribution and employees must pay tax on this reimbursement. For those who do not have an employer and do not receive employment benefits, the income-related contribution is 4.4%. The contribution of self-employed people is individually assessed by the tax department. Contributions are collected centrally and distributed among insurers based on a risk-adjusted capitation formula. The government pays for the premiums of children up to the age of eighteen.

In China, prices of medical schemes are set at reasonable amounts for employees, while medical schemes for more sophisticated health services are set above cost-efficient standards mainly to cross-subsidize the delivery of basic services that general public would need (Yip, W. and Hsiao,W. 2008). However, this created many moral hazards because providers had the incentive to offer sophisticated care even when unnecessary, especially through utilizing high-tech medical equipment and drugs whenever possible (Blumenthal, D and Hsiao,2005). Due to these cost increases and lack of schemes, a significant segment of the Chinese population, especially the rural population who generally have lower income and less social security provisions, had trouble accessing adequate medical schemes and care. For example, the 2003 National Health Survey shows that 46% of the rural residents who were ill did not seek health care and 40% of these people identified cost as the main reason (Yip, 2009).

In Taiwan, medical schemes are not required for those who are suffering from catastrophic illnesses, living in remote areas, or women giving birth. Other exemptions are available for specific populations, such as veterans, household dependants of deceased veterans, low-income households, children under the age

of three, and registered tuberculosis patients who receive treatment at specific contracted hospitals (Bureau of National Health Insurance, 2013).

Ghana has prioritized universal coverage, defined as ‘access to adequate healthcare for all at affordable price’ WHO, (2005), and has put in place policies and programmes to meet this goal (Osei-Akoto, 2003). A number of health financing reforms have been implemented aimed at increasing overall resources to the health sector and ensuring equitable allocation (Atimand S, 2001).

Provision of health care services in Kenya is through the public and private sector, with the central government through the Ministry of Health being the largest provider (Kimalu, 2004). Kenya has had a predominantly tax-funded health system, which has gradually undergone a series of health financing policy changes. Like in most low-income countries, healthcare financing policies in Kenya have gone through three successive phases (Audibert, 2004).

1.1.1 National Hospital Insurance Fund Medical Scheme

Kenya has one public health insurance scheme, the National Hospital Insurance Fund (NHIF); a non-profit institution created by an Act of Parliament in 1966 as a department in the Ministry of Health. At inception, NHIF was intended to provide accessible health insurance for salaried public and private sector employees earning a monthly salary of Ksh 1,000 and more. The NHIF has undergone several changes over the years to include more benefits, targeting informal sector households.Many Kenyans continue to have no access to, or cannot afford to pay for their health care needs. It is due to the need to have a medical scheme for Kenyans, that the National Hospital Insurance Fund (NHIF) was conceptualized for implementation, with a view to enabling more effective provision of health cover to all Kenyans, at both the private and public sector. The original Act of Parliament that set up this Fund in 1966 has over the years been reviewed to accommodate the changing healthcare needs of the Kenyan population and to try to sustain the healthcare needs of the nation.This is an indication that

health financing in Kenya has faced numerous challenges, including inadequate funding (Deolitte, 2011).

The health sector reforms that have hitherto taken place (including introduction of National Hospital Insurance Fund, free health services, cost-sharing, exemptions, waivers and out-patient services) have all aimed largely at addressing affordability and access to health care services. Spending to promote access to health care is crucial, given also that Kenya is a signatory to the WHO Abuja declaration. The latter requires member countries to spend at least 15 per cent of their national incomes (GDP) on health (IPAR, 2005).

1.2 Statement of the Problem

Kenya is one of the countries in Africa that has been involved in intensive reforms of its healthcare services in response to patient needs since independence. Atimand S (2000), say that health care reforms have been aiming at increasing overall resources to the health sector as well as ensuring equitable allocation with the ultimate goal of satisfying the contributors. Barnum (2005), states that a financial catastrophe occurs when individuals incur tremendous fraction of their resources to pay for health care. This financial burden can threaten the living standard of poor people in the short and long term. In the short term the current consumption of other goods and services must be sacrificed, in the long term assets must be shifted which leads to depleted saving and debt accumulation, that can drive many families into poverty or sink them even further into poverty.

Ideally, the medical scheme is supposed to fully cover medication of every member. This is due to its perceived contribution in improving the health care status of the members of the scheme. It should manage its members' contribution so as to meet its financial obligations.

Many contributors to medical schemes have had numerous complaints ranging from poor accessibility, non affordability, lack of sustainability and lack

of quality services among others in the universal medical schemes. The fact that employees, continue to have no access to, or cannot afford to pay for their health care needs is a subject of concern; statistics have it that 8% of Kenyans can only afford Medicare. In terms of accessibility, there are very few health institutions, in terms of affordability majority of people cannot afford the healthcare costs due to low wages, in terms of sustainability most health programmes are not viable without government support and lastly in terms of quality of healthcare there are several challenges ranging from the quality of drugs, medical equipment to quality of doctors. It was against this background that the researcher sought to investigate the effectiveness of the police officer's medical scheme on employee satisfaction.

1.3 Purpose of the Study

The purpose of the study was to establish the effectiveness of medical schemes on employee satisfaction in the case of police personnel in Eldoret West sub-county.

1.4 Objectives of the Study

This study was guided by the following objectives;

1. To establish the effectiveness of the medical schemes' accessibility on employee satisfaction.

2. To determine the effectiveness of the medical schemes' affordability on employee satisfaction.

3. To evaluate the effectiveness of the medical schemes' sustainability on employee satisfaction.

4. To establish the effectiveness of the medical schemes' quality of services on employee satisfaction.

1.5 Research Questions

This study was guided by the following research questions;

1. What is the level of accessibility of the medical scheme on employee satisfaction?

2. How does the affordability of the medical scheme meet employee satisfaction?

3. How does the sustainability of the medical scheme meet employee satisfaction?

4. What quality services does the medical scheme offer that meet employee satisfaction?

1.6 Significance of the Study

The results from this study are of great significance to the managers, decision makers, policy planners, business partners and other related stakeholders of the health sector as they give recommendations on sophisticated indicators for health service improvement. It will also help the health sector management in planning for proper resource utilization.

This study is also significant to the government through the ministry of health and other related parastatals in seeking for donor funds to counter healthcare challenges. The government will also get a deeper understanding of the medical scheme and use the research findings to make any necessary policies that will ensure the effectiveness of the medical scheme.

The study has been able to unearth the underlying issues concerning the impediments to satisfaction of employees in relation to medical schemes. It is also an initiating document for other researchers to further discuss and improve the status of healthcare service delivery in Kenya and beyond.

1.7 Delimitations of the Study

The study was limited to the main aim which was to establish the effectiveness of medical schemes on employee satisfaction. The study was limited to police personnel in Eldoret west sub-county. The study focused on both the regular and administration police officers.

1.8 Limitations of the Study

The researcher faced some constraints such as lack of sufficient time and permission to access some data. This was managed through making prior visits to establish the exact time to be used as well as seek permission from relevant authorities. Some respondents did not complete answering the questions, while others failed to give genuine responses. The researcher appealed to the respondents individually for their utmost cooperation.

1.9 Assumptions of the Study

The researcher assumed that respondents would cooperate and give honest responses to the questions in the research tools. The researcher also assumed that all the sampled population had a common understanding on the issues in the tools of data collection. It was also assumed that the sample size chosen was adequate to enable the researcher draw a valid conclusion about the study.

1.10 Definition of Significant Terms as used in the Study

Accessibility Extent to which a consumer or user can obtain a good or service at the time it is needed (D'Ambruoso, 2008). In this study accessibility is used to refer to the ease with which officers can get medical care.

Affordability A measure of a population's ability to afford to purchase a particular item, such as a medical scheme, indexed to the population's income (Mathonnat, 2004).

Effectiveness The degrees to which objectives are achieved and the extent to which

Employee A person who is hired to provide services to a company on a regular basis in exchange for compensation (Witter, 2009)

Medical schemes A scheme that helps employees to pay for their healthcare needs, such as nursing, surgery, dental work, medicine and hospital accommodation (Carrin, 2003)

Quality The standard of something as measured against other things of a similar kind; the degree of excellence of something (Hussein, 2008). It is operationalized to mean the standard of service offered by the scheme.

Satisfaction A happy or pleased feeling because of something that you did or something that happened to you (Stoneman, 2007). Satisfaction in this study implies to the degree to which the medical scheme meets the medical demands of the officers.

Sustainability Creates and maintains the conditions under which humans and nature can exist in productive harmony (Taylor, 2007).

In this study, sustainability refers to the ability of the scheme to guarantee a foreseeable future.

1.11 Organization of the Study

This study is organized into five chapters. Chapter one consists of the background of the study, statement of the problem , purpose of the study, research objectives, research questions, significance of the study, delimitations of the study, limitations of the study, basic assumptions of the study and definition of significant terms. In chapter two the following themes are covered; literature review which is divided into various sub-topics in accordance with the objectives. The theoretical and conceptual framework is provided at the end of the chapter linking the independent and the dependent variables of the study. Chapter three constitutes the research methodology which is divided into several sub-themes: research design, target population, sample size and sampling technique, research instruments, data collection procedure, validity of instruments, reliability of instruments, data analysis procedure, ethical considerations and finally Operationalization of the variables. Chapter four contains data analysis, presentation and interpretation while chapter five provides a summary of findings, discussion, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The importance and main purpose of literature review is to enable a researcher to get more information about their particular topic or area of interest. Literature review gives the researcher all other works done by past studies from other authors, books, journals, Web and newspapers. This chapter will deal with the concept of medical schemes and present a review of different authors' works in relation to the current study objectives of accessibility, affordability, sustainability and quality of medical schemes on employee satisfaction. The chapter discusses a theoretical framework and then presents a conceptual framework.

2.2 Concept of Medical Schemes

In many countries, healthcare challenges continue to determine the face of poverty. Among the off-track millennium development goals, health-related ones figure prominently, with maternal health and health of newborns among the most significant challenges. In many developing countries and 'emerging' economies, disparities between the rich and poor, urban and rural areas continue to exist, and in many cases are rising. At the same time, public funding for health care tends to receive relatively little priority in many countries, and large portions of health care are funded out-of-pocket, causing significant risks of people falling into poverty, or an inability to obtain the necessary care. Emerging economies globally face challenges in health care that are no less significant than in low-income countries, as demographic transitions, economic reforms, and opening up to global markets, all cause new and no less complicated choices, and new diseases, old and new risks continue to emerge(Bozukova, 2009).

Internationally, over the last decade commitments to health care issues have significantly increased, increasing the need to understand the impact of different

policy approaches. In addressing or neglecting health challenges, alongside technical questions, important political choices are being made (Bozukova, 2009). The choices of systems of delivery are deeply political, as the debates in the United States of America illustrate, as well as in China where the debate on the role of state versus market of course has a direct bearing on the health care reform, and have direct implications for the form of social 'contracts' between citizens and their states.

Coverage for health care can be important elements of bottom-up or grassroots organizational efforts, as the case of the self employed women's association in Ahmedabad, India indicates. Neo-liberalism has included a growing and for many misplaced trust in markets to deliver health services, a growing significance of private health care providers, and of private insurance mechanisms. Social insurance has become an increasingly significant mechanism for the funding and delivery of health care, with for example Ghana, Tanzania, the Philippines and Colombia having set up social insurance system, in which like in China the local government plays an important managerial role (Fei, 2010).

The development of medical schemes then became the key factor to address the issues of health globally. China's New Cooperative Medical Scheme (NCMS) is the successor of the nation-wide Cooperative Medical Scheme that existed during the 1950s-1970s. NCMS was developed in response to the decline in health care services since the economic reforms started in 1978, following intense discussions about the form health provisions should take, and has social insurance principles as central organizational principle. The central government launched NCMS pilots in 300 of China's more than 2000 rural counties. It has been implemented in the same way most other policies in China are implemented: according to a centrally determined framework which grants local governments the autonomy to make adjustments given their own regional peculiarities. Policy guidelines for NCMS stipulate that enrolment must be voluntary and catastrophic expenditures must be covered. It is seen as a response to poverty as well as

disparities in health care, and an integral part of the social security system China is building up, with renewed attention since the stimulus package after the financial crisis. While the scheme promises much improvement for protection of the rural population, and coverage expanded very rapidly, lack of funding, financial management issues, and constraints to access and the dualistic system of provision still limit its effectiveness particularly for the poorest populations (lkenbrack, 2008).

Medical schemes are generally understood as health insurance schemes provided by governments to its citizens, especially to low and middle income populations. Recently, apart from governments, several non-government organizations at the community level provide social health insurance in developing countries (lkenbrack, 2008). Medical schemes pools both the health risks of its members, on the one hand, and the contributions of enterprises, households and government, on the other, and is generally organized by national governments, WHO, (2004). Historically, medical schemes originated in developed countries as work related insurance programs and the coverage has been gradually expanded to the non-working parts of the population (Osei-Akoto, 2003). In recent years, these schemes have been introduced as well in parts of the developing world as an alternative to tax financing and out-of pocket payments (Vietnam 1993, Nigeria 1997, Tanzania 2001 and Ghana 2005). Discussions on the implementation of schemes are underway in several countries (South Africa, Zimbabwe, Cambodia, Malaysia) and countries with medical schemes already in place are making vigorous efforts to extend coverage to the informal sector (self-and unemployed, retired people) in countries such as Colombia, Mexico, Philippines, and Vietnam (Angrist,2006). There are examples of medical schemes arising out of community-based health insurance organized through non-governmental organizations and often involving other elements such as micro-credit. These initiatives are generally weak in terms of efficiency and sustainability but have provided a means of

development for government supported extensions to enable greater population coverage (Angrist,2006)

Most medical schemes combine different sources of funds, with government often contributing on behalf of people who cannot afford to pay for themselves WHO (2004). Medical schemes differ from ‘tax based financing’ which typically entitles all citizens and sometimes residents to services thereby giving universal coverage. However, medical schemes entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population WHO (2004). The prime objectives of medical schemes are: to provide health care that avoids large out of pocket expenditure; increase appropriate utilization of health services; and improved health status (International Labour Office, 2008). Medical schemes can bring about welfare improvement through improved health status and maintenance of non-health consumption goods through ensuring that health expenditures are smoothed over time and that there is no significant decline in household labour supply (Berki,2001).

Medical schemes help employees to pay for their healthcare needs, such as nursing, surgery, dental work, medicine and hospital accommodation. It can be described as “insurance” employees are taking out to cover their health costs. Employees (and in certain cases their employer) pay regular contributions to the scheme. There are many advantages to belonging to a medical scheme which include financially protecting employees if they suddenly have to pay large, unexpected medical costs, employees with medical schemes, usually rest assured that there will be no delay in their medical treatment because they don’t have funds to pay for it. Being a member of a scheme also means employees get better medical care because they are treated by private doctors, specialists and hospitals, instead of going to overcrowded public health facilities. The challenges of medical schemes generally is that they are expensive and fees are always increasing, if employees live in a rural area, they often have no access to private health care

facilities and there are often many hidden costs involved with schemes. Medical schemes might only pay a small amount of employee healthcare costs, while employees have to pay the rest out of their own pocket.

However, the effects of different medical schemes have in recent years been evaluated Hsiao (2007) including trials looking into specific effects of these schemes. Moreover, medical health insurance does not provide complete insurance even if it covers the health care costs (Angrist, 2009).With incomplete health insurance there may also be a significant impact on household production through changes in labour supply, reshaping durable consumption or postponement of important life cycle events, drawing down of precautionary savings and borrowing. Management of risk within the household may well imply that even with the presence of health insurance, a substantial amount of borrowing enhances the ability to smooth consumption over the period of major illnesses (Gentler, 2002).

Other barriers that exist in accessing healthcare include distance to the nearest healthcare facility, lack of knowledge, skills and capabilities in filling forms and filing claims, lack of money to pay admission fees (in schemes that reimburse people), and indifferent attitudes of doctors (Sinha,2002). Furthermore, a more recent Mexican trial, in contrast with other published studies, did not find any effect of a medical health insurance scheme (claimed to be universal) on health outcomes, utilization or spending on medications which challenges beliefs held by proponents of universal health insurance schemes. Despite this evidence, health insurance schemes have been given priority in policies of several developing countries (WHO, 2007).

In Africa, Health insurance as we know it today was not always so streamlined. It started with hospital cash products probably the earliest form of health insurance, still sold in many of the major markets around the world. The cover varied as to the level of benefits and deferment periods and in many

markets, was sold as part of a disability income product. In South Africa, the market began developing in the mid-1980s, and by 1989 there were some 50, 000 policies in place. This grew rapidly during the early 1990s, with the main sales channels being direct marketing through mailings and advertisements in the press (Sinha, 2002).

Major medical cover, similar to what we know today, however came with benefits payable on occurrence of major medical events like surgery or chronic diagnosis. These kinds of products became available to South Africans in the mid-1980s, initially sold on a group basis. Since the early 1990s however, these products became available to individual policy holders. They have also been offered on a universal basis where the benefit is packaged with an endowment benefit by a life office (Gentler, 2002).

By 1991 at least 13 South African insurers were marketing either Hospital Cash or major medical policies. These products did not fit clearly into either short-term or life business as they incorporated aspects of both. The initial split of business between life offices and short-term insurers was probably 80/20 as a result of the development skills and financial strength of the life offices. The short-term proportion increased as direct marketing has been used extensively as a sales channel by short-term insurers (Gentler, 2002).

In Kenya medical schemes amendments have in the recent past been implemented. This was done especially to guarantee the medical cover to the citizens. The short-term insurance act and the long-term insurance act have also undergone revision. The 1996 amendments to the long-term act had included medical schemes as funds under the definition of a "life policy" to facilitate the re-insurance of medical scheme benefits by life insurance funds. A separate definition for a "health policy" was introduced and was worded in such a way as to ensure that the way a medical scheme works (i.e. paying medical expenses to a health service provider) is not replicated through a health policy. Thus, demarcation was

considered at the time when the legislation was originally drafted. By 1998 there was a significant market in both group and individual businesses. The new long-term insurance act, the short-term insurance act and the medical schemes act have all been promulgated. The wording in each allowed for the separation between indemnity business and health insurance.

2.3 Accessibility of Medical Schemes on Employee Satisfaction

Health care accessibility is one of the basic human rights. Accessibility means physician-visiting structure, first-line reception, and availability of different physicians, personal house visitation, and the follow-up visits. Many factors are leading patients to feel frustrated when they are admitted to a hospital usually indicated as an embarrassing aspect, is the absence of clinical staff in any working shifts, especially at night time (Vadhana, 2012). Health care accessibility is increasingly being considered as integral to any poverty reduction strategy (Chuma, Gilson and Molyneux, 2007). While, the basic objectives of poverty reduction remains as a central concern; there has been a shift of focus away from poverty reduction per se to social risk management accepted by all governments all over the world. Improved health conditions lie in the provision of medical schemes that leads to an increase in productivity, employee performance, higher life expectancy, saving, investment, decreased debt and expenditure on health care. This would result to greater equity, economic return, social and political stability (Government of Kenya, 2010).

According to Kimani, (2004), the origins of insurance go back many years, whereby members of a community helped those who suffered loss in some form or another. People would be prepared to help their neighbors who face difficulties; because they believed their families could similarly be aided by others when they require such help. After years of neglect in favor of vertical health programmes, community based small and large scale study’s and donor directed thematic health investments, which form one strong medical scheme are again seen by policy makers and donors as essential to achieving sustainable gains (Chuma, 2009).

Employees' health both in the public and private sector is a crucial livelihood asset, when the poor becomes sick or injured their entire household can be in danger of losing its household income because poor people usually have limited source of income to prevent them from impoverishment. Millions of people die prematurely each year globally especially in poor countries due to easily preventable diseases. Each year the world is losing more than 11 million children due to poor access to preventive health care. In the least developed countries health spending constitutes about US$ 11 per person per year which is below the WHO minimum estimate of US$ 30 – US$ 40 per person for essential intervention.

There is need to improve geographic access to primary and emergency services by putting in place community based health points in the rural areas and establishment of community based health planning and service (CHPS) zones country wide, also improving financial access for the financially vulnerable especially the indigent and poor group of people who cannot afford the health insurance premium (Barnum, 2005). According to Chuma (2007), there is need to improve socio-cultural access - for priority groups (children, women, elderly, disabled people with chronic disease) for instance by exempting the elderly and the children of insured members from premium payment, inclusion of maternal care as well as caesarean delivery in the medical scheme package is one way of addressing the priority health challenges.

Chuma (2009) confirms the fact that majority of the African population does not have access to modern health facilities and another 40% have no access to safe drinking water and sanitation. Africa though it represents only 10% of the global population accounts for 63% of individuals living with HIV/AIDS and 90% of malaria infections worldwide. As it is continuously mentioned out of pocket payment is the major means of accessing health care in most of the African countries. One of the commonly cited barriers to access and possibly utilization of health care services is physical location of the health services. In Spain language

barrier is an issue especially for the migrant population. This has barred direct communication between the workers and health care providers (Magana and Hovey, 2003). Another unfortunate barrier is the lack of transportation. Often, employees travel in groups and may not have access to their own vehicles. In these cases, the workers often rely on public means which are unreliable and inconsistent. The workers then pay daily or weekly fees to take them to and from work, the store or other places. The lack of transportation often affects all aspects of a worker's life including their nutrition, mental health, health seeking behaviors and recreational activities (Villarejo, 2003).

2.4 Affordability of Medical Schemes on Employee Satisfaction

Affordability is the ability to meet the recurrent premiums in order to benefit from the medical care offered. The costs associated with health care, and the prevalence of chronic and complex conditions, can combine to make health services unaffordable for many middle and lower level income people. For example, Australians experience higher rates of chronic conditions such as circulatory disease, diabetes and kidney failure. These chronic conditions often need to be managed in conjunction with other health concerns such as substance use disorders or poor mental health, (Scrimgeour and Scrimgeour, 2008). In the Rwandan Study Study, membership varied from 5.6% to 7.7% in the lowest and highest income category, respectively; yet, this difference was found not to be statistically significant. One indication though in this study that affordability matters, is that large households with more than five members had a greater probability to enrol in the health care insurance than others. The explanation given is that contributions were kept flat, irrespective of household size up to seven members; the average contribution per household member was therefore less than for smaller families, inducing greater enrolment. It was recognized that such contributions could be a financial obstacle to membership. Contributions are also generally levied as flat sums, which is a disadvantage for the poorest: flat

contributions are regressive, a flat-rate contribution as a percentage of income being higher for poor than for the non-poor (Carrin, 2003).

Another affordability issue is notice in terms of the cost of pharmaceutical. Pharmaceutical costs are an additional, often hidden, economic barrier to accessible health care. Also, some people's lack of confidence or familiarity with using pharmacies to purchase medicines further compounds their poor access to required medications (Stoneman J. and Taylor S. 2007).One of the great advantages of health insurance is it reduces households' vulnerability against the financial difficulty of out of pocket expenses resulting from catastrophic illness. The benefit of National Health Insurance is it raises pool of funds to pay for health care cost of large groups of people (McIntyre D, Gilson L and Mutyambizi, 2005), further argue that 'ways by which people will be encouraged to enroll in a scheme is for the insurer to ensure that health services are actively purchased for the scheme members also to negotiate reasonable prices, ensure that services in the benefit package are available and to monitor quality of care'. In the researcher's estimation, this depends upon the control mechanisms put in place, the calibre of people at the helm of affairs and the degree to which they live up to their responsibility.

Australian authorities address potential affordability problems through employing salaried health professionals so that they do not need to charge a fee for service (Hayman N., White, N. and Spurling G. 2009). This strategy also allows practitioners and health workers to spend more time with clients; thereby enabling them to discuss a broader range of concerns in a given consultation. Tabor (2005) maintains that mutual health insurance scheme provides one reliable way by which poor communities manage health risks in combination with publicly financed health care services. Tabor (2005), further argues that 'these schemes are small scale, voluntary, organized and managed in a participatory manner. They are often designed to be simple and affordable and to draw on resource of social solidarity

and cohesion to overcome problems of small risk pools and moral hazards, exclusion and cost escalation'

2.5 Sustainability of Medical Schemes on Employee Satisfaction

Sustainability in health schemes is the ability of all the stakeholders to make the health insurance viable and operational for a long period of time without collapsing, thus, ensuring perpetual existence of health insurance by all the stakeholders. Health insurance schemes cannot be implemented in isolation. The success of their implementation depends on factors like affordability, unit of enrolment, distance, timing, quality and trust. Financial sustainability of national health insurance funds is a pressing concern for many developing countries in Europe which have health care systems funded primarily by national insurance contributions. Bulgaria, currently in the process of implementing a health care reform, is among the countries tackling this issue. Golinowska, Kocot and Sowa (2007) define financial sustainability as the level of revenues being equal to or higher than the level of expenditures, on an annual basis.

According to Stoyanova (2006), there should be three "pillars of health insurance": the first two of them mandatory and the third one optional. The first "pillar" should be national insurance like the one provided by the NHIF. The national insurance should cover a well-defined basic package of services, and the NHIF contributions should equal to 6% of monthly income. The second "pillar" should be mandatory complementary private insurance, which would guarantee an extended package of medical services, and the monthly contributions for that should equal 3% of monthly income. Finally, the third "pillar" should be optional supplementary private insurance, which would most likely be used by people with high income. Within 'pillars of health insurance' model, the Bulgarian government would pay for both the compulsory national insurance and the mandatory complementary private insurance of children, pensioners, and poor and unemployed adults (Bozukova, 2009).

The Kenyan health sector is relatively unsustainable since it relies heavily on out-of-pocket payments. Government funds are mainly allocated through historical incremental approach, (Mwabu, 2008). The sector is largely underfunded and health care contributions are regressive (i.e. the poor contribute a larger proportion of their income to health care than the rich).

Health financing in Kenya is fragmented and there is very limited risk and income cross-subsidization. The country has made little progress towards achieving international benchmarks including the Abuja target of allocating 15% of government's budget to the health sector, (Government of Kenya, 2001).User fees and other out-of-pocket payments (OOPs) have impacted negatively on utilization of health care services in Kenya. In reference to World Health Organization (2006), the majority of the population cannot afford to pay for health care, the poor are less likely to utilize health services when they are ill, and wide disparities in utilization exist between geographical regions and between urban and rural areas. Socio-economic and geographic inequities are wider for inpatient care than outpatient care. Those who pay for care incur high costs that are sometimes catastrophic and adopt coping strategies with negative implications for their socio-economic status, while others simply fail to seek care.

Shrestha (2000) explains that an aging population's demand for medical care services is high because the elderly experience a lot more health problems compared to younger individuals. This is why Shrestha (2000) argues that in every health care system, aging of the population leads to increased medical care expenditures. Arise in the number of elderly people in a population creates cost pressures for every health care system. This is in tandem with the view that health insurance should be re-evaluated to ensure its sustainability through sound policies.

2.6 Quality of Medical Schemes on Employee Satisfaction

Quality of care has been mostly defined in clinical terms focusing on biomedical outcomes. According to D'Ambruoso, Achadi, Adisasmita, Izati, Makowiecka and Hussein (2008) 'over time, conceptualizations of quality of care have broadened, acknowledging that care must be provided within the resource constraints of the health system and, therefore, also focus on resource use, cost, sustainability and other organizational aspect of care. They argue, in addition, that following the classic framework quality of health insurance, conceptualizations of quality of care have been proposed, incorporating elements related to the service user; interpersonal aspects of care and patient's satisfaction.' 'The client provider interface, patient satisfaction and aspects of the user's experience of care are particularly important in health insurance schemes. They further argue that 'the degree to which people who have and their immediate families engaged with these services will be, in part, dictated by the perceived quality of care, as defined by the interpersonal aspects, specifically the client-provider interactions'.

The quality of care offered through the health insurance schemes is a factor to be considered if we are to achieve the goals of that particular health sustainability. In Guinea-Conakry, focus group discussions were organized with 137 persons sampled from the member and non-member population. In the 12 discussions that were held, quality of care was mentioned 383 times by participants as an important factor in the population's attitude towards this particular scheme. Most of the time, participants referred to rapid recovery, good health personnel, good drugs and a nice welcome at the participating health facilities as the most important features of quality. When membership was discussed specifically, lack of quality of care was cited as the most important cause of non-enrolment (WHO, 2003).

One of the core advantages that the employees are anticipating from insurance scheme is convenience. Vadhana (2012) defines convenience as the comfort in approaching a set of standard quality of care such as chances of seeing

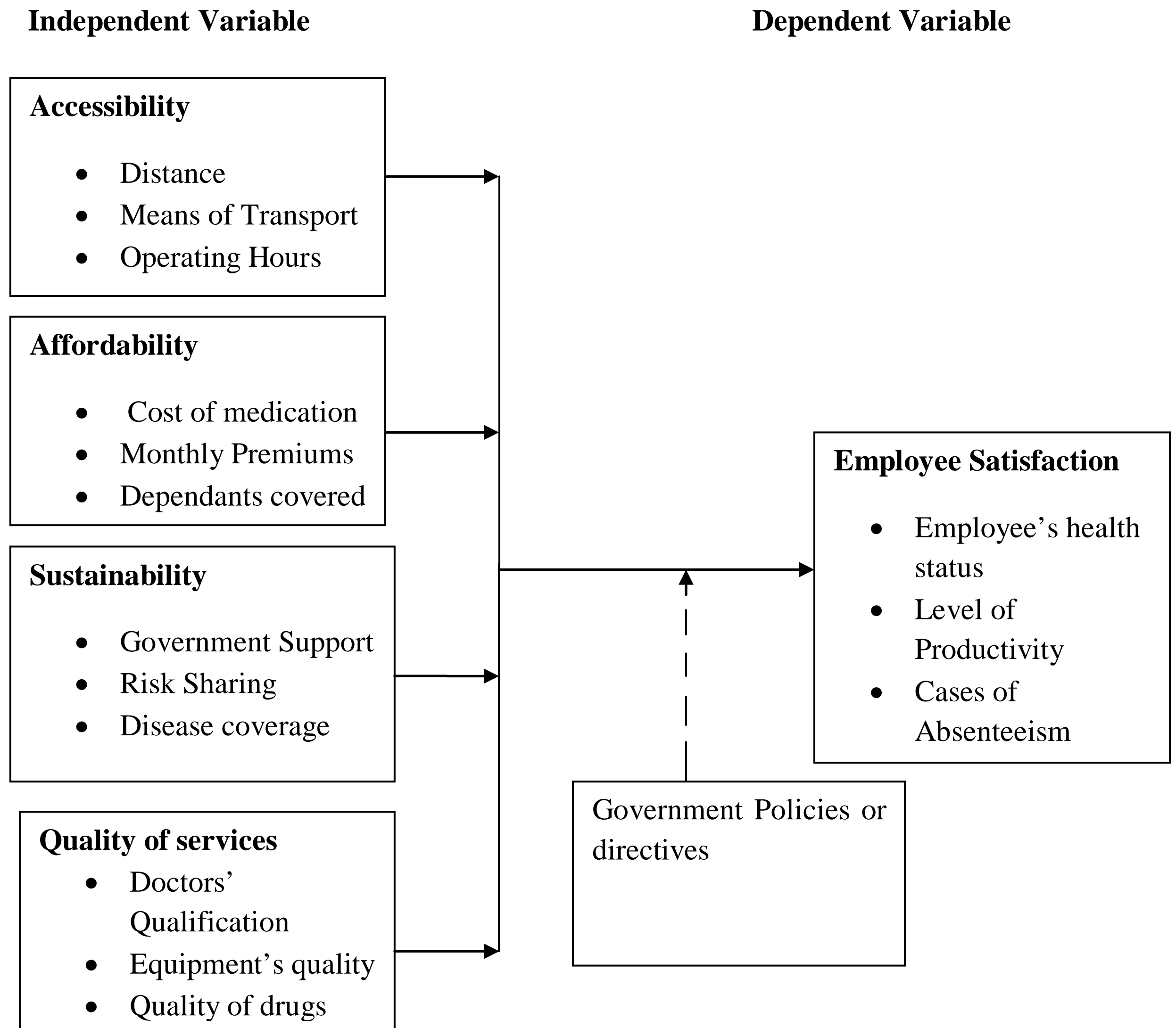
wanted physicians, adequate waiting time, ease of meeting the required expectation and qualified services. Users usually will come back to receive services from where they are satisfied. Researchers can use this characteristic to differentiate the quality of services provided. In a study of patients' satisfaction in the outpatient department of Chulalongkorn Hospital by Sriratanabul and Pimpakovit, a significant factor led the majority of the respondents to feel uncomfortable with the services provided was long waiting time. 83% of the respondents showed positive feeling towards services provided in the department while disappointed with very long waiting time to receiving services (Vadhana, 2012).The success of any insurance scheme is dependent upon the degree to which the service providers can successfully integrate with the members of the insurance scheme. This integration, they emphasized, needs to be backed up with appropriate clinical skills to manage members of the scheme who are ill. These clinical skills are, in turn, contingent upon an enabling environment comprising equipment, supplies, infrastructure, education and training, supervision and supportive political and policy environment.

2.7 Theoretical Framework

This study was guided by the two factor theory also known as Herzberg's motivation- hygiene theory and dual factor theory of 1966. This theory states that there are certain factors in the work place that cause job satisfaction , while a separate set of factors cause dissatisfaction. It was developed by the psychologist Fredrick Herzberg (1966) who theorized that job satisfaction and job dissatisfaction act independently of each other. In this theory, individuals are not content with the satisfaction of their lower order needs at work for example those needs that are associated with minimum salary levels, rather individuals look for the gratification of higher level psychological needs that have to do with achievement, recognition, responsibility, advancement and nature of work itself. This theory suggests that to improve job attitudes and productivity, administrators must recognize and attend to both sets of characteristic of satisfaction and dissatisfaction.

This theory relates to our study because healthcare is a basic human right that needs to be satisfied all through. When the healthcare of employees is accessible, affordable, sustainable and of high quality the workers will be extremely satisfied and in return motivated to work and this motivation manifests itself in the way they carry out their duties, a case in point is that we might not have cases of absenteeism from duty or the country will realize a high degree of security because the police officers will be pro-active in handling crime. In relation to the conceptual framework of the study it is seen that the dependent variable of satisfaction is determined by the independent variables of accessibility, affordability, sustainability and quality of healthcare, if the police officers have accessible, affordable sustainable and quality healthcare then they are satisfied.

2.8 Conceptual Framework



Source: Author's Own Compilation (2014)

Figure 1: Conceptual Framework

In this study, the conceptual framework is a diagrammatic presentation of the relationship between the independent variables and the dependent variable. Here, the four independent variables that determine the effectiveness of medical schemes are; accessibility, affordability, sustainability and quality of service. Accessibility of medical schemes is measured through distance of health facilities, means of transport and operating hours among other factors. Affordability is in

terms of premium costs and extent of cover to dependant while sustainability is achieved through risk sharing and government support, quality of services is via doctor's qualifications, quality of drugs and equipment. The dependent variable is employee satisfaction which manifests itself through higher productivity, lack of absenteeism and complaints at work among others. Government policies can affect the effectiveness of medical schemes which in turn can affect employee satisfaction if implemented. In this study, a government directive or policy is the intervening variable and it affects the relationship between the independent and dependent variables for example if a government decides to remove healthcare subsidies it means that healthcare funding will be us-sustainable because most medical schemes receive government support.

2.9 Summary of Literature Reviewed and Knowledge Gap

This chapter has presented a review of literature related to effectiveness of medical schemes on employee satisfaction. All over the world, financial burdens need to be addressed because they affect the accessibility, affordability, sustainability and quality of medical schemes that affects the satisfaction of employees.

Past scholars such as Chuma, Gilson and Molyneux, (2007) in their literature have argued that improved health conditions lie in the provision of medical schemes that leads to an increase in productivity, employee performance, higher life expectancy, saving, investment, decreased debt and expenditure on health care. In addition to issues concerning medical schemes, Barnum, (2005) stated in his study that there is need to improve geographic access to primary and emergency services by putting in place community based health points in the rural areas and establishment of community based health planning and service (CHPS) zones country wide, also improving financial access for the financially vulnerable especially the indigent and poor group of people who cannot afford the health insurance premium. However, it is also important to point out that there are many factors such as affordability, accessibility, quality of service and sustainability of

the medical schemes that past scholars such as Chuma, Gilson, Molyneux (2007) and Barnum (2005) and other industry thinkers that have not been dealt with and perhaps are key issues for effective medical scheme to improve employee satisfaction. Therefore there exists the gap which has made this study a relevant study. It is on this basis therefore that the researcher sought to fill the existing gap by finding out the effectiveness of the medical scheme's on employee satisfaction.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodology and procedures that were adopted while carrying out the study. It presents the research design, the target population, the sample size and sampling techniques, sampling procedure, the data collection instruments, the data collection procedure, piloting of instruments, validity and reliability of instruments, data analysis procedure, ethical considerations and Operationalization of the variables. Each of the sub-headings mentioned above is separately explained below.

3.2 Research Design

The study employed descriptive research design. According to Kothari (2004), descriptive research design is concerned with describing, recording, analyzing and reporting conditions that exist or existed. Kerlinger (2003) argues that this method is widely used to obtain data useful in evaluating present practice in providing basis for decision. Research undertaking involves many cost implications hence this design was deliberately selected for the study because it allowed for quick data collection at a comparatively cheap cost.

3.3 Target Population

A population is a complete set of individuals, cases or objects with some common observable characteristics (Mugenda and Mugenda, 1999). This study mainly focused on police personnel and scheme managers in the Eldoret West Sub-county. Both the administration police and their regular counter parts were targeted. The police personnel were selected because of the nature of their duties which involves a lot of movements and working long irregular hours. Schemes managers on the other hand were selected because of the prior knowledge

concerning the effectiveness of the medical scheme towards employee satisfactions. This kind of conditions makes them more vulnerable and thus probably the greater beneficiary of the medical scheme. The study target population comprised of 10 medical scheme managers, 310 administrative officers and 275 regular police. The study therefore targeted a total of 595 respondents.

3.4 Sample size and Sampling Technique

The study used Krejcie and Morgan (1970) sample size calculator to get the ideal sample size for police officers and also adopted census sampling technique to select the scheme officers.

3.4.1 Sample Size

The sample size was found to be 235 respondents both police officers and scheme managers at 5% margin of error and 95% confidence level from the Krejcie and Morgan table. Of these, 225 were police officers where the administration police were 119 and the regular police were 106. These two figures were arrived at by taking the 310 administration officers and dividing by the total figure of 585 then multiplying this result by the Krejcie and Morgan table sample size of 225 to get the exact number of administration officers to be sampled. The same was done for the regular police. These two figures came to 119 and 106 respectively. The study then employed census sampling technique for the case of scheme managers. The distribution of the respondents is as shown in the table 3.1 below.

Table 3.1 Target Population and Sample Size

Target Group	Target Population	Sample Size
Administration police	310	119
Regular police	275	106
Scheme managers	10	10
Total	**585**	**235**

Source: Ministry of Interior and Co-ordination of National Government, Eldoret, March 2014

3.4.2 Sampling Procedure

This study employed the simple random sampling technique. This method was ideal because each respondent was given an equal opportunity of being selected from their payrolls and the sample being generalized to the larger population.

3.5 Data Collection Instruments

The data collection instruments are tools used to collect information from the intended target population. The data collection instrument that was used in this study was the questionnaire. A questionnaire is a list of written questions that can be completed in the presence or absence of a researcher. The Questionnaires consisted of both open ended and closed questions. Open ended questions required the respondent to answer questions by narrating their experiences and giving their opinions and this generated qualitative data while the closed questions required a Yes or No answer. Both of these types of questions were administered to the respondents so as to gather information. The questionnaires enabled the researcher to collect data within a shorter time since most of the information was easily described. The questionnaire was used because it is deemed to be the method that

collects a lot of information over a short period of time. A total of 225 questionnaires were administered to the respondents.

3.5.1 Piloting of Instruments

To get validity of the research instruments, the researcher piloted the instruments by distributing twenty nine (29) questionnaires to respondents in Iten town, which is not part of the area being sampled. The results of the piloted questionnaires enabled the researcher to determine the consistency of responses to be made by respondents and adjust the items accordingly by revising the document.

3.5.2 Validity of Instruments

The research purposed to ensure validity of research instruments by using simple language free from jargon that made it easy to be understood by the respondents. The researcher also intended to seek the opinion of individuals who could render intelligent judgment about their adequacy. The researcher also engaged her supervisor and a healthcare expert to ensure that the questions tested or measured what they were supposed to measure.

3.5.3 Reliability of Instruments

Reliability refers to a measure of the degree to which research instruments yield consistent results (Mugenda and Mugenda, 1999). The reliability of data collection instruments was determined from the pilot study where the researcher administered the research instruments in Iten Town. The study administered questionnaires to the same respondents twice. These respondents were twenty nine in number this being 5% of our total population, the questionnaires were administered within a span of one week, and this confirmedthe test-retest reliability.

3.6 Data Collection Procedure

The study used both secondary and primary data. The secondary data was obtained from the records while the primary data was obtained from the respondents. After seeking the consent of the University of Nairobi and other stakeholders, the researcher sought the consent of respective ministries. In collecting data, the researcher visited the respondents within a span of one week to two weeks to allow time for the respondents to fill in the questionnaires. Also, the researcher explained the purpose of the visit to the respondents. This assured the respondents of their confidentiality of any information they gave.

3.7 Data Analysis Procedure

Based on the data collection instruments, data was analyzed both quantitatively and qualitatively. The data from the tools were coded and entered into the Statistical Package for Social Sciences (SPSS) version 16. This computer aided software for research assisted the researcher to present the data. Open-ended questions were analyzed through reporting themes and quotas emerging. The data was analyzed using descriptive and inferential statistics. The descriptive statistics used frequency tables and graphs to present the findings of the study. The study used the regression model of inferential statistics to show the relationship between the independent and dependent variables.

3.8 Ethical Considerations

This research gave attention to the ethical issues associated with carrying out research. This study dealt with people as respondents. Therefore, the researcher assured the respondents of their confidentiality. The researcher considered the fact that participation in research is voluntary. This is why the researcher took time to explain to the respondents the importance of the study and therefore requested the respondents to participate in the study by giving information relevant for the study. The researcher created good rapport with the respondents to establish good working relationship with the participants.

3.9 Operationalization of Variables

Table 3.2 shows how the variables were operationalized

Objectives	**Variables**	**Indicators**	**Measuring scale**	**Type of analysis**	**Tool of Analysis**
To establish the medical schemes' accessibility on employee satisfaction.	**Independent** Medical schemes' accessibility	• Distance • Means of Transport • Operating Hours	Ordinal	Descriptive Statistics Inferential	Frequency tables, graphs
To determine the medical schemes' affordability on employee satisfaction.	**Independent** Medical schemes' affordability	• Total cost • Premiums • Dependants covered	Ordinal	Descriptive Statistics Inferential	Frequency tables, graphs
To evaluate the medical schemes' sustainability on employee satisfaction.	**Independent** Medical schemes' sustainability	• Government Support • Risk Sharing • Disease	Ratio	Descriptive Statistics Inferential	Frequency tables, graphs
To establish the medical schemes' quality of service on employee satisfaction.	**Independent** Medical schemes' quality of service	• Doctors Qualification • Equipment's quality	Nominal	Descriptive Statistics Inferential	Frequency tables, graphs
	Dependent Employee satisfaction	• Level of Healthy workforce • Level of Productivity • Cases of	Nominal	Descriptive Statistics Inferential Statistics	Frequency tables, Graphs

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter presents the findings of the study. Data was collected and analysed through the use of both descriptive and inferential statistics. The data was then presented in tables and graphs and the findings discussed. This enabled the researcher to be able to draw inferences on the effectiveness of medical schemes on employee satisfaction. Data findings were then linked with the researcher's opinion in relation to the existing knowledge for the intricate interpretation and discussion. This chapter is organized into sections beginning with the presentation of respondents' background information and the subsequent sections have been organized following the research objectives. A total of 225 police officers (regular and administrative) from Eldoret west Sub County were involved in filling the questionnaires. These were self administered questionnaires.

4.1.1 Response Rate

The researcher sought to find out the response rate of the respondents. 203 out of the 225 questionnaires administered were comprehensively filled. This represented a response rate of 90.2%. This response rate was considered adequate for reliability and generalization of the study.

4.2 Background Information of the Respondents

The study sought to assess the background information of the respondents in terms of their gender, age, section, their level of education and whether they had a medical scheme. The results were as tabulated below.

4.2.1 Gender

The study sought to assess the respondents' background information in terms of gender. This was necessary to determine the numbers of men and women in the police force and find out any gender disparities in the workforce. This was analyzed and presented in table 4.1

Table 4.1 Gender of Respondents

Gender	Frequency (f)	Percentage
Male	148	72.9
Female	55	27.1
Total	**203**	**100.0**

From the above findings, out of the 203 respondents, 148 (72.9%) of them were male while the females were 55 (27.1%). The purpose of collecting data from both male and female sexes was to avoid gender bias and also to obtain relatively accurate data. However, the study noted that the majority of the respondents were male. This could be because traditionally, it is perceived that the role of security is the responsibility of the men thus women have not participated much in security issues.

4.2.2 Ages of the respondents

It was necessary to also assess the respondents' information in terms of age. The ages were segmented into a five year difference in order to accommodate respondents of every age bracket. This was presented on table 4.2.

Table 4.2 Age range of respondents

Age range	Frequency (f)	Percentage (%)
20-25	9	4.4
26-30	72	35.5
31-35	63	31.0
36-40	21	10.3
41 and above	38	18.7
Total	**203**	**100.0**

According to table 4.2, majority of the respondents 72(35.5%) were aged between 26-30years. 63(31%) were aged between 31 and 35years, 38(18.7%) were aged 41 years and above, 21(10.3%) were aged between 36 and 40years and only

9(4.4%) were aged between 20 and 25 years. From the table, it is evident that most of the police officers are youth aged between 26 and 30 years. These youth are physically fit and are capable of doing physical jobs such as being in the police force.

4.2.3 Section of the respondents

In terms of police section the respondents were divided into two; the administrative police and the regular police. This data was analyzed and presented on the table 4.3

Table 4.3 Section of the respondents

Section	Frequency (f)	Percentage (%)
Administration	126	62.1
Regular	77	37.9
Total	**203**	**100.0**

From the data, there were 126(62.1%) administration police and 77(37.9%) regular police. The majority of the respondents were from the administrative section.

4.2.4 Level of education

The study investigated the background information of the respondents in terms of their level of education and presented the information in table 4.4.

Table4.4 Level of Education of the Respondents

Level of Education	Frequency (f)	Percentage (%)
Primary	27	13.3
Secondary	109	53.7
Post Secondary	67	33.0
Total	**203**	**100.0**

From the data, 109(53.7%) were of secondary level of education, 67(33%) were of post secondary level of education and only 27(13.3%) were of primary level. The majority of the respondents were of secondary level of education because they are recruited after completing secondary school.

4.2.5 Medical scheme

The researcher asked the respondents whether they had a medical scheme. The findings were as shown on table 4.5

Table 4.5 Medical scheme

Medical scheme	Frequency (f)	Percentage (%)
Yes	203	100.0
No	0	0

According to table 4.5, all the police officers both regular and administrative confirmed that they have a medical scheme.

4.3 Specific Information based on the Objectives of the Study

4.3.1 Effectiveness of accessibility of the Medical Scheme on Employee Satisfaction

Objective one of the study sought to establish the effectiveness of accessibility of the medical scheme and its effects on employee satisfaction. The findings were analyzed and presented in the table 4.6

Table 4.6 Effectiveness of accessibility of the Medical Scheme on Employee Satisfaction

Key: SA: Strongly Agree, A: Agree, N: Neutral, D: Disagree, SD: Strongly Disagree, T: Total, M: Mean, F: Frequency, %: Percentage

Statements		SA	A	N	D	SD	T	M
The medical facility is within reach	F	79	101	6	2	15	203	4.1
	%	38.9	49.8	3	1	7.4	100	82
There are various means of transport to the medical facility	F	55	103	15	12	18	203	3.8
	%	27.1	50.7	7.4	5.9	8.9	100	76
The facility is usually ready and willing to provide the required service	F	41	92	21	29	20	203	3.5
	%	20.2	45.3	10.3	14.3	9.9	100	70

From the study findings (table 4.6), it was found that majority of the respondents 82% were of the opinion that the medical facility is within reach, 76% of them were of the opinion that there are various means of transport to the medical facility while 70% of them agreed with the fact that the facility is usually ready and willing to provide the required service.

It is clear from the study findings above that majority of the respondents (82%) agreed with the fact that the medical facility is accessible. This could be as a result of the strategic physician-visiting structure, first-line reception, and availability of different physicians, and the follow-up visits by the medical scheme officers.

4.3.2 Effectiveness of affordability of the Medical Scheme on Employee Satisfaction

The study second objective sought to establish the effectiveness of affordability of the medical scheme on employee satisfaction. The findings were analyzed and presented in the table 4.7

Table 4.7 Affordability of the Medical Scheme on Employee Satisfaction

Key: SA: Strongly Agree, A: Agree, N: Neutral, D: Disagree, SD: Strongly Disagree, T: Total, M: Mean, F: Frequency, %: percentage

Statements		SA	A	N	D	SD	T	M
Cost of medication at the medical facility is reasonable	F	42	67	26	22	46	203	3.1
	%	20.7	33	12.8	10.8	22.7	100	62
The monthly premiums for the scheme are within my budget	F	36	61	29	40	37	203	3.0
	%	17.7	30	14.3	19.7	18.2	100	60
The medical scheme takes care of all my dependants	F	20	66	23	25	69	203	2.7
	%	9.9	32.5	11.3	12.3	34	100	54

From the study findings (table 4.7), it was found that majority of the respondents 62% were of the opinion that cost of medication at the medical facility is reasonable, 60% of them were of the opinion that the monthly premiums for the scheme are within their budget while 54% of them said that the medical scheme takes care of all their dependants.

It is clear from the findings as shown by table 4.7 that majority of the respondents (62%) are of the opinion that the cost of medication at the medical facility is reasonable. This is due to the reason that the monthly premiums deducted are not too high and the same scheme still takes care of their dependants.

4.3.3 Effectiveness of Sustainability of Medical Scheme on Employee Satisfaction

The researcher investigated the effectiveness of sustainability of the medical scheme on employee satisfaction. The findings were analyzed and presented in the table 4.8

Table 4.8 Effectiveness of Sustainability of Medical Scheme on Employee Satisfaction

Statements		SA	A	N	D	SD	T	M
The government is supportive of the scheme in terms of subsidies hence the scheme is sustainable	F	52	98	19	10	24	203	3.7
	%	25.6	48.3	9.4	4.9	11.8	100	74
The scheme covers patients with all diseases both the expensive (chronic) and the simple ailments (not so expensive) hence equal risk sharing	F	28	89	16	40	30	203	3.2
	%	13.8	43.8	7.9	19.7	14.8	100	64
The risk sharing in terms of premium (monthly) contribution among employees makes the scheme very sustainable	F	33	81	36	26	27	203	3.3
	%	16.3	39.9	17.7	12.8	13.3	100	66

The study findings on table 4.8, showed that majority of the respondents confirmed that the government is supportive of the scheme in terms of subsidies hence the scheme is sustainable, while 66% of the respondents said that the risk sharing in terms of premium (monthly) contribution among employees makes the scheme very sustainable and 64% of them agreed with the fact the scheme covers patients with all diseases both the expensive (chronic) and the simple ailments (not so expensive) hence equal risk sharing.

From the study findings shown on table 4.8, it is evident that majority of the respondents (74%) agreed with the fact that the government is supportive of the scheme in terms of subsidies hence the scheme is sustainable. This is attributed to the government's concerted effort on its citizens' healthcare as the government has always advocated for the attainment of universal health care for its entire people because this is one of the social pillars of Kenya's millennium development goals in achieving its vision 2030 objectives.

4.3.4 Effectiveness of Quality of Medical Scheme's services on Employee Satisfaction

The forth objective of the study sought to find out the effectiveness of quality of the medical scheme's services on employee satisfaction. The findings were analyzed and presented in the table 4.9

Table 4.9 Quality of Medical Scheme's services on Employee Satisfaction

Key: SA: Strongly Agree, A: Agree, N: Neutral, D: Disagree, SD: Strongly Disagree, T: Total, M: Mean, F: Frequency, %: percentage

Statements		SA	A	N	D	SD	T	M
The medical facility has qualified doctors who treat patients	F	65	100	23	6	9	203	4.0
	%	32	49.3	11.3	3	4.4	100	80
The medical equipment at the hospital is up to the required standards	F	41	76	43	25	18	203	3.5
	%	20.2	37.4	21.2	12.3	8.9	100	70
There are sufficient drugs at the accredited hospital	F	25	58	33	26	61	203	2.8
	%	12.3	28.6	16.3	12.8	30	100	56

From the study findings (table 4.9), it was found that majority of the respondents 80% were of the opinion that the medical facility has qualified doctors who treat patients, 70% of them were of the opinion the medical equipment at the hospital is up to the required standards while 56% of them said that there are sufficient drugs at the accredited hospital.

From the study findings, it is observed that most of the respondents (80%) agreed that the medical facility has qualified doctors who treat patients. This is probably due to the fact that Eldoret West sub-county hosts Kenya's second largest referral hospital, the Moi Teaching and Referral hospital which is well equipped with modern and sophisticated medical equipments and well trained medical personnel.

4.3.5: Employee Satisfaction

The study sought to establish theemployee's satisfaction in relation to the medical scheme. The findings were analyzed and presented in the table 4.10

Table 4.10: Employee Satisfaction

Key: SA: Strongly Agree, A: Agree, N: Neutral, D: Disagree, SD: Strongly Disagree, T: Total, M: Mean, F: Frequency, %: percentage

Statements		SA	A	N	D	SD	T	M
Good health status of the employees in the police force is attributed to the effectiveness of the medical scheme offered	F	52	62	47	27	15	203	3.5
	%	25.6	30.5	23.2	13.3	7.4	100	70
There is a high level of productivity due to medical schemes effectiveness in the police force	F	25	88	40	41	9	203	3.4
	%	12.3	43.3	19.7	20.2	4.4	100	68
There are less cases of absenteeism as a result of the quality of service offered by the established medical scheme in the police force	F	28	89	63	44	6	203	3.4
	%	13.8	43.8	17.7	21.7	3	100	68
The poor medical scheme in the police force has resulted to the reported high number of complaints by the police officers	F	44	81	23	29	26	203	3.4
	%	21.7	39.9	11.3	14.3	12.8	100	68

From the study findings on table 4.10, it is evident that majority of the respondents (70%) said that good health status of the employees in the police force

is attributed to the effectiveness of the medical scheme offered while 68% and a similar percentage of the respondents were of the opinion that there is high level of productivity due to medical schemes effectiveness and less cases of absenteeism as a result of the quality of services offered in the police force. However, 68% of the respondents were of the opinion that, the medical scheme in the police force is poor and thus has resulted in the high number of complaints by police officers.

The findings indicate that, 70% of the respondents agree that good health status of the employees in the police force is attributed to the effectiveness of the medical scheme offered. This however, shows that the medical scheme is effective in terms of the quality of services offered by the scheme which in turn has contributed to the less cases of absenteeism among the police officers.

4.4 Correlation Statistics

The study investigated the linear relationship between variables as indicated in table 4.11 below. Pearson correlations results in table 4.11 showed that employees' satisfaction were positively and significantly correlated to all the independent variables i.e. accessibility of the medical scheme, affordability of the medical scheme, sustainability of the medical scheme and the quality of medical scheme's services

Quality of medical scheme's services were most highly positively and significantly correlated to affordability of the medical scheme ($r=0.540$, $p< 0.05$). The quality of medical scheme's services had 54% positive relationship with the affordability of the medical scheme.

Sustainability of the medical scheme was the second variable to be positively related to accessibility of the medical scheme ($r=0.402$, $p<0.05$). This showed that sustainability of the medical scheme had 40.2% positive relationship with accessibility of the medical scheme.

However, employees' satisfaction were most highly and significantly associated with affordability of the medical scheme ($r=0.376$, $p<0.05$). This implies that affordability of the medical scheme had 37.6% positive relationship with employees' satisfaction. The study established further that quality of the medical scheme's services was the second variable to be positively correlated with employees' satisfaction ($r=0.371$, $p<0.05$). This shows that the quality of the medical scheme's services had 37.1% positive relationship with employees' satisfaction.

Accessibility of the medical scheme was third variable to positively correlate with employees' satisfaction as shown by $r=0.266$, $p<0.05$) implying that accessibility of the medical scheme had 26.6% positive association with employees' satisfaction.

However, sustainability of the medical scheme was the least variable that was positively and significantly correlated with employees' satisfaction as indicated by $r= 0.164$, $p<0.05$ indicating that sustainability of the medical scheme had 16.4% positive relationship with employees' satisfaction.

The findings provided sufficient evidence to suggest that there was a linear relationship between the accessibility of the medical scheme, affordability of the medical scheme, sustainability of the medical scheme and quality of the medical scheme's services and employees' satisfaction. This show that in order to achieve employee satisfaction, the factors discussed by the study which are the affordability, accessibility, sustainability and quality of service of the medical scheme must be enhanced and effectively improved

Table 4.11 Correlation statistics

Correlations					
	Accessibility of the Medical Scheme	Affordability of the Medical Scheme	Sustainability of Medical Scheme	Quality of Medical Scheme's services	Employee Satisfaction
Accessibility of the Medical Scheme	1				
Affordability of the Medical Scheme	.264**	1			
Sustainability of Medical Scheme	.402**	.370**	1		
Quality of Medical Scheme's services	.243**	.540**	.480**	1	
Employee Satisfaction	.266**	.376**	.164**	.371**	1

** Correlation is significant at the 0.01 level (2-tailed)

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of findings, discussions, conclusions reached and recommendations following the objectives of the study. The study sought to find out the effectiveness of medical schemes on employee satisfaction; a case of police personnel in Eldoret West Sub County. This study set out to establish the medical schemes' accessibility on employee satisfaction, determine the medical schemes' affordability on employee satisfaction, evaluate the medical schemes' sustainability on employee satisfaction and establish the medical schemes' quality of service on employee satisfaction.

5.2 Summary of the findings

Based on the responses of the study, the researcher summarized the findings as follows: From the findings concerning the effectiveness of accessibility of the medical scheme's on employee satisfaction, 82% of the respondents indicated that the medical facility is within reach, 76% of the respondents observed that there are various means of transport to the medical facility and70% of the respondents said that the facility is usually ready and willing to provide the required service.

In respect to the effectiveness of affordability of medical scheme the study revealed that 62% of the respondents were of the opinion that the cost of medication at the medical facility is reasonable, 60% of them were of the opinion that the monthly premiums for the scheme are within their budget while 54% said that the medical scheme takes care of all their dependants

On the effectiveness of medical schemes' sustainability, results from the study indicated that majority of the respondents confirmed that the government is supportive of the scheme in terms of subsidies hence the scheme is sustainable while 66% said that the risk sharing in terms of premium (monthly) contributions

among the employees makes the scheme very sustainable. 64% agreed with the fact the scheme covers patients with all diseases both the expensive (chronic) and the simple ailments (not so expensive) hence equal risk sharing

From the findings on effectiveness of quality of medical scheme's on employee satisfaction, it was established that majority of the respondents 80% were of the opinion that the medical facility has qualified doctors who treat patients, 70% were of the opinion that the medical equipment at the hospital is up to the required standards while 56% of them said that there are sufficient drugs at the accredited hospital.

Finally, On employee satisfaction indicators, majority of the respondents (70%) said that good health status of the employees in the police force is attributed to the effectiveness of the medical scheme offered while 68% and similar percentage of the respondents were of the opinion that there is high level of productivity due to medical schemes' effectiveness, less cases of absenteeism as a result of the quality of services offered by the medical scheme to the police force. However, 68% of the respondents were of the opinion that, the medical scheme in the police force is poor and thus has resulted in the high number of complaints by police officers.

5.3 Discussion of the Findings

This section gives a detailed discussion on the findings of the study. The idea of medical schemes and employee satisfaction has existed for many years and has revolved largely on employers and employees. It has been observed that employees play an important role in the sustenance of the developing countries' economies and their production is a function of their health status among other factors. Medical schemes play an important role in the health care system of any nation by modifying it to match the country's health care needs of its people. Medical schemes are increasingly recognized as a tool to finance health care provision in developing countries and have the potential to increase utilization and better protect people including the employees against health expenses and address

issues of equity (WHO, 2000). Consequently, this study assessed the effectiveness of medical schemes on employee satisfaction: a case of police personnel in Eldoret west Sub County.

5.3.1 Effectiveness of accessibility of the Medical Scheme on Employee Satisfaction

According to the study findings on table 4.6 on the effectiveness of accessibility of the medical scheme on employee satisfaction, the medical facility is accessible as agreed by a majority of the respondents. These outcomes concur with the findings by Chuma, Gilson and Molyneux (2007), who argued that health care accessibility is increasingly being considered as an integral to any poverty reduction strategy. While, the basic objectives of poverty reduction remains a central concern; there has been a shift of focus away from poverty reduction per se to social risk management accepted by all governments all over the world. Improved health conditions lie in the provision of medical schemes which leads to an increase in productivity, employee performance, higher life expectancy, saving, investment, decreased debt and expenditure on health care. This would result to greater equity, economic return, social and political stability (Government of Kenya, 2010). Employees health both in the public and private sector is a crucial livelihood asset, when the poor becomes sick or injured their entire household can be in danger of losing its household income because poor people usually have limited source of income to prevent them from impoverishment.

In addition, Barnum (2005) in his findings on accessibility of medical facilities suggested that there is need to improve geographic access to primary and emergency services by putting in place medical facilities within the reach of the people country wide. The findings by Barnum also suggested that there is need for improving the operation of the medical facilities to cater for emergency cases.

5.3.2 Effectiveness of Affordability of the Medical Scheme on Employee Satisfaction

The study found out that the cost of medication at the medical facility is reasonable as confirmed by the 62% agreement of this fact. This relates to Stoneman's and Taylor's (2007) literature which suggests that, one of the greatest advantages of health insurance is to reduce households' vulnerability against the financial difficulty of out of pocket expenses resulting from catastrophic illness. The benefit of National Health Insurance is to raise a pool of funds to pay for health care cost of large group of people. McIntyre (2005) further argues that ways by which people will be encouraged to enrol in a scheme is for the insurer to ensure that health services are actively purchased for the scheme members also to negotiate reasonable prices, ensure that services in the benefit package are available and to monitor quality of care'. In the researcher's estimation, this depends upon the control mechanisms put in place, the calibre of people at the helm of affairs and the degree to which they live up to their responsibility.

It was revealed that the medical scheme is affordable to most of the police officers as the monthly premiums deducted on every individual were within their financial limits as indicated by 60% of all the respondents. This however, relates to the outcomes of the findings by Carrin (2003) who stated that affordability is the ability to meet the recurrent premiums in order to benefit from the medical care offered. The costs associated with health care, and the prevalence of chronic and complex conditions, can combine to make health services unaffordable for many middle and lower level income people.

It was found from the study that the medical scheme is sufficient to take care of all the employees' dependants as indicated by 54% of all the respondents. This concurs with study findings by Tabor (2005) which maintains that Mutual health insurance schemes provide one reliable way by which beneficiaries of the scheme manage health risks in combination with publicly financed health care

services. These schemes are often designed to be simple and affordable and to draw on resource of social solidarity and cohesion to overcome problems of small risk pools, exclusion and cost escalation'.

5.3.3 Effectiveness of Sustainability of Medical Scheme on Employee Satisfaction

The literature of Golinowska, Kocot, andSowa (2007) confirms that health insurance schemes cannot be implemented in isolation thus the government is supportive of the scheme in terms of subsidies making the scheme sustainable as indicated by the 74% agreement of this opinion by the respondents. The success of their implementation depends on factors like affordability, unit of enrolment, distance, timing, quality and government support. This can perhaps be attributed to the fact that the government through the national hospital insurance fund has been in the forefront in advocating for the adoption of the scheme by all employees.

However, the Kenyan health sector is relatively unsustainable since it relies heavily on out-of-pocket payments. Government funds are mainly allocated through historical incremental approach (Mwabu, 2008). The sector is largely underfunded and health care contributions are regressive (i.e. the poor contribute a larger proportion of their income to health care than the rich). Financial sustainability of national health insurance funds is a pressing concern for many developing countries which have health care systems funded primarily by national insurance contributions. Kenya, currently in the process of implementing a health care reform, is among the countries tackling this issue.

Medical insurance premiums should be shared among the employees; the government should be supportive of the scheme since it covers patients with all diseases both the expensive and simple ailments hence equal risk sharing as indicated by 64% of the respondents. This is only ensured by the health insurance scheme. The works of Stoyanova, I. (2006) suggests that there should be three pillars of health insurance in any nation that the government should support: the first two of them mandatory and the third one optional. The first pillar should be

national insurance like the one provided by the NHIF. The national insurance should cover a well-defined basic package of services, and the NHIF contributions should equal to 6% of monthly income. The second pillar should be mandatory complementary private insurance, which would guarantee an extended package of medical services, and the monthly contributions for that should equal 3% of monthly income. Finally, the third pillar should be optional supplementary private insurance, which would most likely be used by people with high income. Within the pillars of health insurance model, the Kenyan government should pay for both the compulsory national insurance and the mandatory complementary private insurance of employees and their dependants.

5.3.4 Effectiveness of Quality of Medical Scheme's services on Employee Satisfaction

According to this study, 80% of the respondents showed positive feeling towards services provided in the medical facility while partly disappointed with the unavailability of drugs in the hospital pharmacy as most of them noted to have been receiving prescription on drugs from pharmacies outside the medical facility.

The quality of any medical scheme is dependent upon the degree to which the service providers can successfully integrate with the members of the medical scheme. These findings are consistent with the findings of Vadhana (2012) who stated that the integration of service providers and members of the medical scheme needs to be backed up with appropriate clinical skills to manage members of the scheme who are ill. These clinical skills are, in turn, contingent upon an enabling environment comprising equipment, supplies, infrastructure, education and training, supervision and supportive political and policy environment of the respondents agreed that the medical facility has qualified doctors who treat patients.

Hussein (2008) suggested that the quality of care offered through the Health insurance schemes is a factor to be considered if we are to achieve the goals of that particular health sustainability and maintain the desired quality.

5.3.5 Employee Satisfaction

The findings indicate that, 70% of the respondents agree that good health status of the employees in the police force is attributed to the effectiveness of the medical scheme offered. This however, shows that the medical scheme is effective in terms of the quality of services offered by the scheme which in turn has contributed to the less cases of absenteeism among the police officers.

For employee satisfaction to be enhanced, their health status must be considered. The amount of output of employees is dependent on their health. The medical scheme has been successful in ensuring employee satisfaction in that it has managed to cover their health status. Medical schemes help employees to pay for their health care needs such as nursing, surgery, dental work and medical accommodation.

The findings concurs with the study by Berki (2001) which states that medical schemes can bring about welfare improvement through improved health status and maintenance of non-health consumption goods through ensuring that heath expenditures are smoothed over time and that there is no significant decline in employee productivity.

However, the effects of different medical schemes have in recent years been evaluated including trials looking into specific effects of these schemes as in the findings of (Achadi, 2007). Achadi further stated that medical health insurance does not provide complete insurance even if it covers for the health care costs. With incomplete health insurance there may also be a significant impact on employee production through changes in labour supply, reshaping durable consumption or postponement of important life cycle events, drawing down of precautionary savings and borrowing.

5.3.6 Discussion on the interview schedule for the scheme's managers

Majority of the scheme's managers said that the medical is effective in terms of accessibility, affordability, sustainability as well as on the quality of services offered by the medical facility. In addition, most of them were of the opinion that government and other stakeholders such as USAID should provide more support to the facility particularly in terms of funding as this would only ensure that up to standard equipments are purchased that would increase the quality of services being offered to the scheme's beneficiaries. The managers were however satisfied with kind of support the government is providing them with. On the accessibility matter, the managers articulated that the facility has been made operational all the time as Health care accessibility is one of the basic human rights. The medical facility has ensured continuous present of Clinical staffs in any working shifts, especially at night time so as to avoid making patients to feel frustrated when they are admitted to a hospital as a result of absence of the clinical staff. Also most of the managers acknowledged that the medical facility has sufficient ambulance vehicles that helped in cases of emergency.

The medical scheme's managers also stated that the medical scheme is effective in terms of affordability as the monthly premiums deducted from the employees are within their financial capabilities. These limits are priorities so as to ensure that the costs associated with health care, and the prevalence of chronic and complex conditions, which can combine to make health services unaffordable for many middle and lower level income people are catered for by the scheme. Majority of them however, raised some concerns that most of the employees particularly police officers need to be educated in order for them to understand the benefits that comes with scheme other than them viewing it as a way of targeting their monthly salaries.

Concerning effectiveness of the medical scheme in terms of sustainability, majority of the interviewed scheme's managers alleged that the scheme's stakeholders have made the health insurance viable and it has been operational for

a long period of time without collapsing. Their success is attributed to implementation factors like effective affordability, consistent unit of enrolment, considerable distance, good timing in terms of addressing issues of concern, substantial quality and trust by all the stakeholders of the medical facility thus making the scheme sustainable and efficient.

The managers added further that the services being offered in the hospital are of high quality as they have sufficient and qualified practitioners that provide people with such services. However, some of the scheme's mangers raised some concerns that more qualified doctors are needed in order to improved the services offered as well as to ensure that the medical officers are not overworked due to shortage of personnel. This conquers with the literature of D'Ambruoso, Achadi, Adisasmita, Izati, Makowiecka and Hussein (2008) who have argued that over time, conceptualizations of quality of care have broadened, acknowledging that care must be provided within the resource constraints of the health system and, therefore, also focus on resource use, cost, sustainability and other organizational aspect of care. They argue, in addition, that following the classic framework quality of health insurance, conceptualizations of quality of care have been proposed, incorporating elements related to the service user; interpersonal aspects of care and patient's satisfaction. The medical scheme's managers therefore said that enhancing all these factors surrounding medical scheme will result to satisfaction of employees.

5.4 Conclusion to the Study

Medical schemes play an important role in the health care system of any nation by modifying it to match the country's health care needs. This is because medical schemes are increasingly recognized as a tool to finance health care provision of people and have the potential to increase utilization and better protect people including the employees against health expenses and address issues of equity.

Medical schemes should be very accessible to citizens of a country. This is so because health care accessibility is one of the basic human rights. It was found from the study that the ultimate barrier to accessibility of the medical schemes by the employees is the lack of transportation. Often, employees travel in groups and may not have access to their own vehicles. In these cases, the workers often rely on public means which are unreliable and inconsistent. The workers then pay daily or weekly fees to take them to and from work, the store or other places. The lack of transportation often affects all aspects of a worker's life including their nutrition, mental health, health seeking behaviours and recreational activities.

Medical schemes should be made affordable to all employees. The government should ensure a proper system of contribution by employees. However, there is need to meet the recurrent premiums in order for all employees and their dependants to benefit from the medical scheme offered by ensuring that the costs associated with health care, and the prevalence of chronic and complex conditions, are combined to make health services affordable for many middle and lower level income people.

The study concluded further that sustainability of the medical scheme is essential and it is the duty of any government to ensure that such facilities are sustainable. However it is evident from past studies by Mwabu, G (2008) and Bozukova, M (2009) that the Kenyan health sector is relatively unsustainable since it relies heavily on out-of-pocket payments. Government funds are mainly allocated through historical incremental approach which has not yielded much to the scheme to make it more sustainable. It was also observed from the study that the health financing in Kenya is fragmented and there is very limited risk and income cross-subsidization.

In regards to the quality of services offered by the scheme, the study observed that majority of the respondents showed positive feeling towards services provided in the medical facility though some of the respondents expressed some dissatisfaction with the unavailability of drugs in the hospital pharmacies as most

of them noted to have been receiving prescription on drugs from pharmacies outside the medical facility. Therefore there is need to ensure that the drugs are made available within the medical facilities and modern medical equipments are adopted as this will ensure that high standard quality of services are offered.

On employee satisfaction, the study observed most of the police officers are not satisfied with the medical scheme that has been implemented. Majority of them expressed some concerns on monthly premiums deducted on their salaries. However, in order to enhance the police satisfaction of the medical scheme, their health status must be considered first and also ensuring that the scheme is more affordable and easily accessible. On contrary, the study however concluded based on the findings that the medical scheme has been successful in ensuring employee satisfaction in that it has managed to cover their healthcare requirements. The medical scheme has also helped employees to pay for their health care needs such as nursing, surgery, dental work and medical accommodation.

5.5 Recommendation

The researcher recommends that:

i. There is need to ensure that medical facilities are available all over the country. This will ensure that employees get fast access to medication wherever they are in need and handle emergency cases. For ease of accessibility, there is also a need in eliminating barriers that exist in accessing the medical facility.
ii. The cost of medical schemes in Kenya is currently high in terms of premium deduction and pharmaceutical costs thus most of the employees cannot afford them. The study therefore recommends that in order to address affordability problems, the government should set in to subsidize more on the amount of premiums contributed by employees. The government should also provide cheaper and quality drugs and other medical equipments in the hospital in a way to reduce the cost of medication.

iii. The medical scheme should be made viable to all employees and also should be operational for long without collapsing. This can be guaranteed only through proper management of the scheme as well provision of adequate funding by the government and other agencies such as non Governmental Organizations (NGO's). The medical scheme should not be implemented in isolation but by ensuring that the implementation caters for requirements such as affordability, unit of enrolment, distance, quality and trust.

iv. The study further recommends that the services to be offered by the medical scheme should be of high quality in order to meet the employees' needs and ensure their satisfaction. However, overtime conceptualization of quality of care has been broadened acknowledging that care must be provided within the resource constraints of the health system at the same time making sure that adherence to quality is maintained.

v. Employee satisfaction is the chief concern of every employer in order to achieve the goals and objectives of the organization. The study therefore recommends that every employee should be medically covered to ensure satisfaction.

5.6 Implications for further studies

The researcher suggests the following areas for further studies;

i. Effectiveness of medical schemes on employee motivation

ii. Challenges faced by medical schemes in provision of their services

iii. Factors that influence the adoption of the medical schemes

iv. An assessment of other factors that influence employee satisfaction

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APPENDICES

APPENDIX 1: LETTER OF TRANSMITTAL

Pauline Jeruto Kurgat

P.O. BOX 3091-30100

ELDORET

Dear Respondent,

I am a student of the University of Nairobi pursuing a Masters Degree in Study Planning and Management. I am conducting an academic research on the '**Effectiveness of Medical Schemes on Employee Satisfaction**'. This questionnaire is aimed at finding out the effectiveness of medical schemes on employee satisfaction, a case of police personnel in Eldoret West Sub-county. Please give your personal views to these questions which are purely for academic purposes towards the attainment of a Master of Arts Degree in Study Planning and Management from University Of Nairobi.

Thank you.

Yours faithfully,

Pauline JerutoKurgat

E-mail: pkurgat@nhif.or.ke

Phone: +254 722 289 952

APPENDIX II: QUESTIONNAIRE FOR POLICE OFFICERS

Instructions

Please respond to the questions by ticking on the appropriate response.

SECTION A: GENERAL INFORMATION

1. Gender Male [ ] Female [ ]

2. Age 20-25 [ ] 26-30 [ ] 31-35 [ ] 36-40 [ ] 41 and Above [ ]

3. Police Section Administration [ ] Regular [ ]

4. What is your level of Education? Primary [ ] Secondary [ ] Post Secondary [ ]

5. Do you have a medical scheme? YES [ ] NO [ ]

SECTION B: ACCESSIBILITY OF THE MEDICAL SCHEME ON EMPLOYEE SATISFACTION

6. To what extent do you agree/disagree with the following statements on the level of accessibility of the medical scheme on employee satisfaction?

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

Statement	**5**	4	3	**2**	**1**
The medical facility is within reach					
There are various means of transport to the medical facility					
The facility is usually ready and willing to provide the required service					

7. How far do you live from your medical facility?

1-5 Kilometers [ ] 6-10 kilometers [ ]

11-15 Kilometers [ ] 16-20 Kilometers [ ]

8. How accessible is the medical facility?

Accessible [ ] Not accessible [ ]

SECTION C: AFFORDABILITY OF THE MEDICAL SCHEME ON EMPLOYEE SATISFACTION

9. To what extent do you agree/disagree with the following statements on the affordability of the medical scheme on employee satisfaction?

5: Strongly agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

Statements	**5**	4	3	**2**	**1**
Cost of medication at the medical facility is					
The monthly premiums for the scheme are within my budget					
The medical facility takes care of all my dependants					

10. How affordable is your medical scheme?

Very Affordable [ ] Affordable [ ] Unaffordable [ ]

11. What are your monthly premiums to the medical scheme in Kenya shillings?

0-500 [ ] 501-1000 [ ] 1001-1500 [ ] over 1500 [ ]

12. Is the medical scheme sufficient for you and all your dependants?

YES [ ] NO [ ]

SECTION D: SUSTAINABILITY OF MEDICAL SCHEME ON EMPLOYEE SATISFACTION

14. To what extent do you agree/disagree with the following statements on the level of sustainability of the medical scheme on employee satisfaction?

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

Statements	**5**	4	**3**	**2**	**1**
The government is supportive of the scheme in terms of subsidies hence the scheme is sustainable					
The scheme covers patients with all diseases (no discrimination), risks are shared hence the scheme is sustainable					
The risk sharing in terms of premiums (monthly) contribution among employees makes the scheme very sustainable					

15. Do you have a chronic/terminal disease?

YES [ ] NO [ ]

16. Everyone in my office is at the end of the month deducted the premium for the employees medical scheme

Agree [ ] Disagree [ ]

SECTION E: QUALITY OF THE MEDICAL SCHEME'S SERVICES ON EMPLOYEE SATISFACTION

17. To what extent do you agree/disagree with the following statements on the quality of the medical scheme on employee satisfaction?

    5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

Statements	5	4	3	2	1
The medical facility has qualified doctors who treat					
The medical equipment at the hospital is up to the required standards					
There are sufficient drugs at the medical facility					

19. Are you attended by qualified doctors?

    YES [ ] NO [ ]

20. What is the state of the medical equipment used in the facility?

    Bad [ ] Good [ ]

21. The last time you had a prescription at the accredited hospital, where did you purchase the drugs?

    At the hospital pharmacy [ ] At a chemist outside the hospital [ ]

SECTION F: EMPLOYEE SATISFACTION

22. To what extent do you agree/disagree with the following statements on the indicators of employee satisfaction?

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

Statements	5	4	3	2	1
Good health status of the employees in the police force is attributed to the effectiveness of the medical					
There is a high level of productivity due to the medical schemes' effectiveness in the police force					
There are less cases of absenteeism as a result of the quality of services offered by the medical scheme in the police force					
The poor medical scheme in the police force has resulted to the reported high number of complaints by					

23. Have you ever been sick?

YES [ ] NO [ ]

24. How effective is the medical scheme in relation to your performance in the police force?

Very effective [ ] Effective [ ] Not effective [ ]

25. Do the quality of services offered by the medical scheme contribute to employees' absenteeism?

YES [ ] NO [ ]

APPENDIX III: INTERVIEW SCHEDULE FOR SCHEME' MANAGERS

1. What is the level of accessibility of the medical scheme on employee satisfaction?

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2. How does the affordability of the medical scheme meet employee satisfaction?

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3. How does the sustainability of the medical scheme meet employee satisfaction?

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4. What quality services does the medical scheme offer that meet employee satisfaction?

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5. Is the medical facility open 7 days a week 24 hours a day?

YES [ ] NO [ ]

6. How is the Government's support towards the scheme?

Sufficient [ ] In-sufficient [ ]

7. Does the medical facility have qualified doctors who treat patients?

YES [ ] NO [ ]

8.Is the medical equipment at the hospital up to the required standard?

YES [ ] NO [ ]

If No, briefly give reasons why and what should be done to improve the quality of the medical equipment in the hospital

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9. What is your take on the availability of drugs at the medical facility?

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