AN EVALUATION OF THE BEST COST SHARING PRACTICES
BEING IMPLEMENTED BY PUBLIC HOSPITALS IN KENYA

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OCTOBER, 2012
DECLARATION

I declare that this is my original work and has not been presented in any other University of College for examination /Academic purpose

Signed: .............................................. Date: ........................................

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The research project has been submitted for examination with my approval as the student’s supervisor.

Signed: .............................................. 11/11/2012

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DEDICATION

This research paper is dedicated to my family for their support, encouragement, understanding and prayers towards the successful completion of this course.
Without the Almighty God’s blessings and the joint efforts of my family, family friends, colleagues and the University of Nairobi, the achievement of this goal would not have been possible. A special thanks to the University of Nairobi for assisting me realize my dream. I am most grateful to my Supervisor, Anjela Kithinji for guiding me through this process. Her wisdom, encouragement and expertise was an invaluable asset. Despite heavy academic responsibilities, she unselfishly and graciously shared her expertise and time in helping me carry out the research project.

A special thanks to my parents who were instrumental in encouraging me to enter into the MBA programme. They have followed my progress from the start to finish always encouraging me to carry on.

Finally, but not least, thanks to my wife, Lucy and other family members who endured life without my full attention. Your prayers, understanding, support and encouragement helped me to keep going.

To each of my supportive friends who kept me in your prayers and offered words of encouragement, THANK YOU.
ABSTRACT

Cost sharing financing schemes are seen as an option for extending insurance coverage in low-income countries, particularly among rural and informal sectors of society. Over the years other community financing mechanisms have been added including introduction of prepaid insurance like schemes such as National Hospital Insurance Fund (NHIF), Community Health Funds (CHF), National Social Security Fund (NSSF) and National Social Health Insurance Schemes. The main purpose of this study was to determine the best cost sharing practices being implemented by Public Hospitals in Kenya.

The study adopted the descriptive research design. A descriptive survey is a process of collecting data from the members of a population in order to determine the current status of the sample under study with respect to one or more variables. The study population consisted of all the seven Provincial General Hospitals and three Referral Hospitals registered in Kenya by December, 2010. A Sample of two referral hospitals was randomly selected from the population and all the seven provincial hospitals were studied. The data analysis for this study was based on quantitative approach using descriptive and inferential statistics. The data was analyzed with the help of statistical package for Social Sciences (SPSS) version. Percentages, frequencies, pie charts, tables and graphs were used where applicable to facilitate easy understanding. Multiple regression analysis was used to evaluate the statistical relationship between the variables.

The findings of the study revealed that the best cost sharing practices are practices where: the Government promptly finances lost revenues due to exemptions and waivers given by hospitals, there is transparency and accountability in collecting and spending cost sharing funds, funds are regularly audited, health management boards are properly inducted to their duties, monitor and verify collection and expenditure, collection registers exist, health care staff are involved in decision making regarding use of collected funds, health care protection policy exist such that no one is denied health care services due to inability to pay and that citizens are aware of it, there is legal and political framework where political commitment and top management support exist, revenue generated should be an addition to hospital budget allocation and Government budget allocation to hospitals should not reduce with introduction of cost sharing and an accounting information system exist to enhance cost sharing revenue collection and usage. The respondents cited challenges in the implementation of cost sharing practices and from the findings the challenges included: Poverty in communities that increases waivers, difficulty in determining the patients who qualify for waivers, inadequate budget allocation by the government, failure by the government to promptly reimburse the hospitals for costs forfeited through protection policy, inadequate staff to run the funds and that board members are not well trained on financial management and accounting.
It was recommended that the government should promptly fund the exemptions and waivers to reduce the constraints experienced by the public hospitals, the board members should be well trained on financial management and accounting for them to be more competent, budget allocation should be increased, the village elders and the provincial administration officers should be involved in determining the patients who qualify for waiver and more staff should be hired. The government should employ qualified personnel and train existing ones to raise their capacities in order to affirm efficiency and proper utilization of resources and revenue maximization.
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<tr>
<td>HCSF</td>
<td>Health Care Services Fund</td>
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<tr>
<td>FIF</td>
<td>Facility Improvement Fund</td>
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<td>GoK</td>
<td>Government of Kenya</td>
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<td>KHPF</td>
<td>Kenya Health Policy Framework</td>
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<td>HSRS</td>
<td>Health Sector Reform Secretariat</td>
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<td>MRC</td>
<td>Ministerial Reform Committee</td>
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<td>DHMB</td>
<td>District Health Management Board</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<td>PHMT</td>
<td>Provincial Health Management Team</td>
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<td>DMOH</td>
<td>District Medical Officer of Health</td>
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<td>PMOH</td>
<td>Provincial Medical Officer of Health</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>CHF</td>
<td>Community Health Funds</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>OECD</td>
<td>Organisation for Economic Development</td>
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<td>SAP</td>
<td>Structural Adjustment Programmes</td>
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<td>APHIA</td>
<td>Aids, Population and Health Integrated Assistance Programme.</td>
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CHAPTER ONE

1.0 Introduction

The cost sharing programme in Kenya was mooted in the 1984/88 Development Plan (MoH 1984; Owino, 1997). The most forceful policy statements on user fees are contained in the Ministry of Health 1984-88 Development Plan. Seasonal Paper No. 1 of 1986, and the Ministry of Health Concept Paper of 1989 on cost sharing. Details about overall health sector reforms are contained in the Health Policy Framework Paper (MoH.1994). These health reforms, which were to be implemented over fifteen years, included mobilising additional resources; enhancing the role and participation of the private/NGO sector in health care delivery; redefining the role of MoH in health care delivery; organisational and management adjustments; and resource reallocation. Of all of these, health financing was identified as the key constraint to increasing the efficiency and quality of health services in the public health sector. For the same reason, reforms in the health sector were mainly focused on developing alternative financing mechanisms to those provided by government. On the list are strategies such as increased cost recovery, social insurance, maintaining health facilities through communal fundraising efforts (the ‘harambee’ spirit) and community-based health care. A priority area became the introduction of cost sharing (user charges).

1.1 Background of the Study

In the last decade, faced with decreases in both direct Government Financing and reduced donor assistance, many developing countries have attempted to raise additional funds for health by instituting private user charges, cost sharing or user fees for health services that had previously been provided free by Public Health facilities. User fees have been employed fairly extensively throughout the developing world (Hsiao, 1995). There were two major reasons that led to rapid growth of cost sharing of Government health services in African countries: first International Organizations advocated for the introduction of user fees (Akin et al. 1999). After seeing most developing countries were faced with the dilemma of how to provide adequate health services.
the World Bank proposed a solution to Governments to apply a user fee at the point of service delivery both to increase revenue and create a greater rationalization of services (Shaw & Griffin, 1996). The World Bank and International Monetary Fund (IMF) were in particularly strong position to influence policy in African countries as user fees and other cost recovery mechanism were often an integral part of these institutions’ loan conditionality and associated Structural Adjustment Programs (SAP). Uganda introduced user fees on a universal basis in 1993 in order to meet a World Bank loan conditionality (Okuonzi, 2004). The second factor was macro-economic difficulties in many countries related to low growth or negative economic growth, increased indebtedness, limited resources available to Governments for financing and providing health services. This led to financing strategies that placed the burden on service users (Bennet, 1992).

Cost sharing fund is commonly known as Health Care Service Fund (HCSF) or Facility Improvement Fund (FIF). Its objectives include: raising additional revenue to supplement the normal budgetary allocation, improve availability and quality of health care services, improve equity and access to health care services by pooling financial risks and cross-subsidizing costs, strengthen community (users/payers) voice towards improving service quality and accountability and providing financial incentives to health workers when fees are used at the facility where fees were collected (Shaw & Ainsworth, 1995).

In 1987 African Ministers for Health with the support of United Nations International Children Emergency Fund (UNICEF) and World Health Organization (WHO) supported the cost recovery in Mali what has come to be known as Bamako Initiative (UNICEF, 1992). The initiative sought to mobilize resources through community financing to improve health care services and especially ensure drugs availability. In 1997, over 30 African Governments were operating cost recovery programmes (Watkins, 1997). This hasty introduction of user fees raised concerns particularly regarding equity. Therefore, the future challenge for the Governments and partner organizations will be to continue expanding cost sharing program while taking good care of the poors’ needs and well being.

One of the goals of Government of Kenya (GOK) is to promote and improve health status of all Kenyans by making services more effective, accessible and affordable. The health policy of the country revolves around: how to deliver quality health services and how to finance and manage
those services in a way that guarantees their availability, accessibility and affordability to those in need.

At independence GOK committed itself to providing “free” health services as part of its development strategy to alleviate poverty, improve welfare and productivity of its citizens. After several years and despite this commitment the Government was not able to provide free services due to constraints such as SAP, low economic growth, increased population, increased demand for health services, poor management and inappropriate pricing. This led to various health care reforms being introduced such as cost sharing and National Hospital Insurance Fund.

In 1994, the GOK approved the Kenya Health policy framework (KHPF) as a blueprint for developing and managing health services. To operationalize the document, Ministry of Health developed Kenya Health Policy Framework Implementations Action plan and established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) to spearhead and oversee the implementation process. This policy aimed at responding to the following constraints: inadequate funding, inefficient utilization of resources, centralized decision making, inequitable management information system, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increased burden on disease and rapid population growth. The Government of Kenya (G.O.K) introduced cost sharing in Public Health Sector in 1989. It was briefly suspended in 1990 and re-introduced again in 1992. The programme was part of a comprehensive health financing strategy which also included social insurance, efficiency measures and Private Sector development.

1.1.1 Cost Sharing

Cost sharing is a health care cost containment technique which health care services are partially paid for by patients out-of-pocket (Carrin, 2003). This concept is about how employers or Governments subsidize certain benefits such as medical, dental, vision, life insurance and disability. Community members finance or co-finance costs associated with health services. They are more involved in the management of community financing scheme and organization of health services (Carrin, 2003). Community health financing has emerged in developing countries following the challenges that exist in the health financing system which include low economic growth, constraints on the public sector and low organizational capacity (Carrin, 2003).
Cost sharing financing schemes are seen as an option for extending insurance coverage in low-income countries, particularly among rural and informal sectors of society (Kelly, Diop et al, 2006). Over the years other community financing mechanisms have been added including introduction of prepaid insurance like schemes such as National Hospital Insurance Fund (NHIF), Community Health Funds (CHF), National Social Security Fund (NSSF) and National Social Health Insurance Schemes.

The principle of Cost Sharing is not new and has been applied in many countries around the world including Kenya starting from 1989, Tanzania 1993, and Uganda, 1993. Cost Sharing is also referred to as user fees or cost recovery. Objectives of introducing user fees were: First, revenue generation and improvement in quality of Public Health Services especially through availability of medicines and facilities. It was anticipated that user fees would generate significant revenue to cover health care financing gap facing Government Health Services. Enhance community involvement in the management and taking ownership of local facilities. Institutionalizing clients’ power through private provision of basic services is increasingly advocated as an effective means for improving service delivery in Africa.

Second according to international organizations user fees would: prevent unnecessary health service utilization and send price signals to patients about the cost of service at different levels of care and thereby promote appropriate use and adherence to referral mechanisms (Akin et al, 1987) ensure that health care providers are responsive to patient’s needs and concerns to provide good quality care when patients are paying for services, promote equity in that those who could afford to pay would ease the burden on Government who then would concentrate its resources on the poor.

1.1.2 Cost Sharing Practices

Several Cost Sharing Practices exist and include; Equity. Means that everyone should be able to access and use appropriate health services. The main elements of a just health care system can be listed as the universal access, access to responsive care and fairness in financing.

Protection Policy. These are policies that ensure that patients are not denied health care due to inability to pay. They include exemptions and waivers. Cost sharing creates financial barriers to
access, hence it should be accompanied by mechanism to protect the users of health care and people in lower income groups. Exemption is a statutory entitlement to free public services which is granted to individuals that automatically fall under the specified categories. Waiver is granted to patients who are unable to pay. It is used to reduce or eliminate fees for the poor based on an assessment of their ability to pay.

Community participation and control or resources. Cost sharing practices emphasizes that the community should be made fully aware of the principles and implementation mechanisms of cost sharing. Local management committee should represent the community in the Health Management Board.

Usage of Cost-sharing revenue generated. Revenue generated is supposed to be retained and used in the collecting facilities to improve on the quality of services being provided.

Supervision and Monitoring. This assist in monitoring the impact of user fees on key indices such as revenue collection, waivers, exemptions, workload, expenditure, quality of services, fees structure, commodity supply and utilization of services.

Transparency and Accountability. Successful cost sharing policies should be: simple and easy to understand, result in cost savings to the insurance or state generate revenue funds, ensure patients share in the cost of health care, are administratively cost-effective and practical.

It is assumed that health providers will be responsive to the demand by users for a high level of quality and that the users will take great interest in the management of resources, thereby ensuring greater efficiency and effectiveness.

1.1.3 Performance and Efficiency Concepts

Hospital performance may be defined according to the achievement of specified targets, either clinical or administrative. That is the extent to which by the services delivered, the hospital contributes to the improvement of patients health, it complies with the patient’s expectations and ensures equity in delivering medical care among them. The concepts of performance in the health sector include: health improvement or outcomes, effectiveness and quality, patients orientation to services, access, financial and resources management. Performance measurement (PM) for health sector have developed for three classical components of care: Structure, process and outcomes. At the patients level, PM manifests primarily as a measurement of the process or
outcomes of treatment, at the service or program level, as a program evaluation and at the systems level, as a mechanism for organizational control and ensuring efficient use of resources. The general perception is that emphasis in performance measurement in the health sector is on finance and resource management, but performance management goes beyond this to include quality and to ensure that resources are being used appropriately and effectively. Efficiency involves finding the right level of resources for the system and ensuring that these resources are used to yield maximum benefits or results. There are several dimensions of efficiency including cost effectiveness, technical, allocative and incremental output efficiency and they relate both to the ways in which health sector policy is formulated and the ways in which public finances are managed. Cost effective provision of health services involves improving health status of the population for a given budget. The Pacific Business Group on Health (PBGH) defines efficiency as the relative quantity, mix and cost of clinical resources used to achieve a measured level of quality. Health care efficiency refers to how well health care resources are used to obtain health improvements and comprises two component: technical efficiency and allocative efficiency. Technical efficiency is where the output produced at a given level of quality is maximized for a given level of minimum inputs whereas Allocative efficiency involves the least cost combination of inputs for a given output. One of the main arguments for cost sharing is that it can increase efficiency by reducing unnecessary use of health services and encouraging cheaper or more cost effective health care. Duckett(2008) defines allocative efficiency as ensuring the best allocation of resources in the health care system so that the inputs allocated to the health care yield best possible outcomes. He suggests that key elements of allocative efficiency include priority setting among diseases and within diseases (Preventable versus curative) and minimising preventable hospitalisations. Efficiency indicators include; revenue raised, cost incurred, number of day cases per speciality, number of new and return patients and patient’s waiting time before receiving treatment.
1.1.4 The Relationship between Performance and Efficiency

Efficiency is a component of Performance and refers to the comparison between actual and optimal amounts of inputs and products. Performance is defined broadly to encompass a range of activities that maximizes outcomes whereas efficiency can be measured in terms of the systems contribution to the health alone or a composite of goal attainment.

RAND defines efficiency as an attribute of performance that is measured by examining the relationship between a specific product of the health care system and the resources used to create that product.

1.1.5 Public Hospitals

These are hospitals owned by a Government and receives Government funding. Most countries set up public hospitals to address market failure in health care and to improve equity in the provision of medical services. They exist in order to fulfill the Government’s obligations to provide free hospital services to all members of the community. They are viewed by the public as the main manifestation of the health care system and its ability to fulfill a caring role and are therefore significant politically (McKee & Healy, 2000).

Public hospitals are an important part of health system in developing countries and depending on their capacity, act as first referral, secondary or last referral facility. These hospitals are generally responsible for fifty to eighty percent of recurrent Government health sector expenditure in most countries (Barnum & Kutzin, 1993), and utilize nearly half of the total national health expenditure in many of these countries (Mills, 1990).

Essential functions and responsibilities of hospitals include: provision of medical services, preventive health care, rehabilitation and health education, conducting medical education and research, responding to public health accidents and other Government missions such as free immunization, free dressing and supporting teaching practicals. Hospitals change in response to: demand-side pressures such as changing public expectations about the roles of hospitals as a consequence of wider societal and economic change (Mckee & Healy, 2004). Health provision is undertaken by both the public and private sectors. However, due to inadequacies of public sector, the private is found to be playing a leading role in the provision of health services to the population (Ablo & Reinikka, 1998).
1.1.6 Financing of Public Hospitals

Financing sources for public hospitals include: Government fiscal budget (Direct Government Financing and Donor Funding), Private User Charges (Cost Sharing), third party payments such as health insurance and community financing (Kenya Health Policy Framework, 1994). Most countries’ health financing systems have a mixture of these financing sources. Some donors finance programmes directly and report spending to Ministry of Health based on agreed programmes of work (Ensor & McIntyre, 2004). Most continental regions and at global level, taxation financing is the dominant source. Whereas some countries such as France and Germany rely much more heavily on social insurance contributions than general Government sources such as taxation (OECD Health data, 2004). Recent health sector reforms have increased cost sharing in order to make consumer cost conscious. Revenue from cost sharing program have supplemented declining Government revenues and supported significant improvements in the quality of health services. In developing countries, cost sharing provides sixty percent or more of non-personnel recurrent costs in primary health care facilities (Shaw & Ainsworth, 1995).

At the Abuja Declaration, April 2001, Heads of African States and Governments agreed to commit at least fifteen percent of total annual budget to the improvement of the health sector. Most countries have not been able to achieve this. Kenya policy framework of 1994 identified several methods of Health Care financing which include: taxation, donor funds, user fees (cost sharing) and health insurance.

A review of public expenditure and budget in Kenya from financial year 2004/2005 to financial year 2008/2009 show that total health expenditure averages about six percent of total Government spending and about twenty one percent on non-wage recurrent budget (MOH, 2010).

1.2 Statement of the Problem

Although the intentions of introducing cost sharing as financing reforms were good, the outcomes of implementing countries suggest otherwise. Cost recovery has not proven to be a panacea for cash trapped health system in poor countries (Burnham et al 2004). Studies have shown that user fees elicit household coping strategies that can be destructive to families over a long period of time. These include: delaying or not seeking treatment, seeking informal care or self treatment (Sahn et al 2003). Health Services may be obtained at the expense of selling-off assets, removing children from school, reducing food consumption or borrowing (Russell; s.
In addition, African experience demonstrate that exemption mechanism, particularly those aimed at protecting the poor are frequently ineffective (Gilson et al, 2001). The Government of Kenya (GOK) acknowledges that its citizens are entitled to quality, accessible and affordable health care services. Consequently, most of the health sector reforms the Government has undertaken have been necessitated by the need to address fundamental constraints in the health care systems that affect the services delivery. Although the government introduced cost sharing fund in 1989 to alleviate some of the deficiencies faced, complaints against the public hospitals and facilities persist. Such include: lack of essential drugs and complaints about inefficiencies in health systems that “too much money is being spent on hospitals rather than primary care, public funds are spent on inappropriate or cost-ineffective services”. Most studies in Kenya have tried to look at the impact of user fees on utilization of health care (Mwabu & Wang’ombe, 1995). Wagstaff and Claeson(2004) in their study on impact of policies and institutions has shown that policies and institutions are important for increases in spending to have significant effect on health outcomes in achieving the Millennium Development Goals (MDGS). While there have been vast studies on cost sharing practices in public hospitals, no conclusive study has been done on the evaluation of the best cost sharing practices implemented in public hospitals in Kenya. Moreover, cost sharing practices in hospitals has also emerged as a void that need an attention as a result of its popularity. This study therefore filled the void by answering the question: What are the best cost sharing practices being implemented by public hospitals in Kenya and the challenges hindering successful implementation of Cost Sharing practices in public hospitals?

1.2.1 Research Questions

- What are the best cost sharing practices being implemented by the Public Hospitals in Kenya?
- What are the challenges faced in the operation of Cost-sharing funds.
- What are the possible solutions to the challenges?
1.3 Objectives of the Study

1.3.1 General Objectives

The main purpose of this study was to determine the best Cost sharing practices being implemented by Public Hospitals in Kenya.

1.3.2 Specific Objectives

The specific objectives of the study were:

- To evaluate the best cost sharing practices being implemented in Public Hospitals in Kenya.
- To determine challenges that hinders successful implementation of Cost Sharing.
- To determine possible solutions to the challenges faced.

1.4 Value of the Study

The findings of the study may be invaluable to researchers as it may contribute information and insight to theory development on cost sharing. It will therefore produce hither to unavailable information and document all that has been casually known but not documented by the hospitals. The study will therefore form a useful foundation for reference for further researchers and scholars as a basis of further research.

Policy makers such as the government may find the study important in developing strategies and policies to address the challenges faced in the Cost Sharing operation. The study will also yield data and information that might be useful for proper planning and decision making in the health sector. It will inform the government on the various strategic practices and thus inform them on the sustainability of the cost sharing programs. The findings of the study will enable management of the public hospitals to evaluate whether their current management practices are in line with what is expected to enhance the success of cost sharing. Hence, they will have to base their methods, decisions and actions on concrete knowledge of issues of strategic management practices in the public hospitals.
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The purpose of literature review is to find out whether studies have been done on this area before that can help in providing knowledge that can enrich this research. In this chapter the literature review on cost sharing practices in the public health sector in any developed or developing country is reviewed to try and relate with the case at hand. That is the evaluation of best cost sharing practices being implemented by public hospitals in Kenya.

2.2 Theoretical Review

2.2.1 The Theory of Revenue Extraction

This is a theory of different means of obtaining money. The most important means by which states extract revenues from the society is through taxation. Tax revenue constitutes the “life-blood” of the state. The power of taxation proceeds upon the theory that existence of a government is a necessity that it cannot continue without means to pay its expenses, it has a right to compel its citizens and property within its limits to contribute and a duty for macroeconomic stabilization. Different types of taxes exist such as income taxes, corporation taxes, consumption taxes. In addition to conventional economic factors, a states political system, its discount rate, bargaining power and availability of non-state revenues all influence the states ability to tax.

According to Adam Smith (1776) the subjects of every state ought to contribute towards the support of the government as nearly as possible in proportion of their respective abilities. That is, in proportion to the revenue which they respectively enjoy under the protection of the state. Cost sharing borrows from this theory when health services are partially paid for by patients out of pocket.
2.2.2 Theory of Public Goods

Public good is a good that once produced for some consumers, can be consumed by additional consumers at no additional cost and consumers cannot be excluded from consuming the goods. Economic efficiency requires that the government force people to contribute to the production of the public goods and then allow all citizens to consume them. Its an theory of public expenditure. Availability and quality of public good is viewed as instrumental for development in developing countries. Lack of publicly provided infrastructure has been shown to constitute an important bottleneck for development of private firms (Reinikka & Svensson, 2002).

2.2.3 Public Choice Theory

Studies economic behavior of non-market decision makers like politicians, voters and bureaucrats and assumes that man is an egoist rational and utility maximizer (Mueller 1976). Mueller, (1989) Suggests that legislators and government officials have different goals than profit maximization and they exhibit individual utility maximizing behavior. They are involved in increasing their vote bank and achieving budget maximization objectives leading to waste and inefficiencies (Shleifer & Vishny,1994). Politicians and Interest Groups are influenced by rent seeking, power and perks. They pursue their own agendas and not those of the public just as people in business do. It developed from the study of taxation and public spending. It explains how political decision making results in outcomes that conflict with general public preferences. It presents a view that public organizations are controlled by politicians and bureaucrats who are supposed to work in public interest but instead use these organizations for their personal benefits and as a result efficiency of public organizations is less as compared to private organizations because it is costly for politicians to influence private organizations (Shleifer & Vishny, 1997). Private market is projected to improve competition and efficiency.

The reward system in public sector is not oriented towards improving performance, hence there is no incentive for politicians and bureaucrats to control costs. Public managers focus more on delivery than on productivity and efficiency. The theory also argues that public bureaucracies are slow to respond to environmental changes as well as being unresponsive to service users. The rise of New Public Management doctrine is associated with increasing popular and intellectual disenchantment with growth and role of government and
increasing taxation and consequently pressure to curb the expansion of government and shift towards privatisation (Hood, 1991). This theory advocates that the role of Government should be limited. In many Countries, Health Services are being provided through a mixture of public, semi-autonomous Hospitals, non-Government and Private Hospitals.

2.2.4 Economic Theory

Hospitals are both economic and social institutions and survive based on their success in balancing different approaches to their activities. The justification for demand side cost sharing is based on the economic theory that risk avoidance must be balanced against moral hazard in the choice of Insurance Coverage (Pauly M.V, 1968). Too little coverage adversely affects utility because risk averse individuals may be subjected to excessive exposure to unpredictable catastrophic losses. Too much coverage may distort the cost-benefit decision.

In health insurance context, moral hazard has been associated with over-utilization of medical services because the full cost of their decision to consume health care does not fall on to the patients.

Cost sharing is theorized to shift consumption of health care toward the optimal level. Patients' response to cost sharing depends on two assumptions: one. that the elasticity of demand is sufficiently high to induce patients to alter their health care utilization pattern. Two, patients are sufficiently informed to reduce the type of care that yields little clinical benefit. Some economists argue that moral hazard argument is sensible in medical care “only if we consume health care like we consume other consumer goods (John Nyman, 2007).

Uwe Reinhardt & Malcom Gladwell, 2005 argue that while we might indeed consume more soda when it is free, we seek health care when we are sick. Hence patients are not so price sensitive that moving from a positive co-payment to free care causes an explosion in demand for medical services. There are also doubts as to patient's ability to distinguish between beneficial and less essential treatments when forced to reduce care due to cost considerations.

Economic theory indicates three Justifications for state intervention in the health care market; namely: to correct or offset failings in the market for health insurance, to ensure optimal production of the good and to subsidize consumers too poor to buy insurance or the inexpensive health care that the non-poor can finance out-of-pocket.
2.2.5 Transaction Cost Theory (TCT)

The concept of TCT was introduced by Economists John Commons and Ronald Coase who posited that transactions are the central unit in TCT. Coase’s article placed transaction cost at the center of analysis as to why firms exist and suggested that markets and organizations are alternatives for managing the same transactions (Barney & Hesterly, 1996). Williamson (1981) argued that organizations develop to reduce transaction costs and are different based in the type of economic exchanges they expect to govern. TCT has become increasingly influential in explaining the governance of economic activity (Richman & Macher, 2006). It is based on two main assumptions: First, individuals are limited in their ability to predict the future and are therefore subject to bounded rationality. Second, actors are prone to opportunistic behavior due to difficulty in reaching common agreement through contracting (Williamson, 1981). It was designed to address and explain governance choices.

Theoretical framework used in the discussion of health care cost and service delivery choices is influenced by whether Government intervention is necessary to address issues in the health care markets or whether an open competitive market strategy is adequate. Those opposed to Government intervention believe that the distribution of health care is based on the principle of need, an approach that fails to allocate health care resources efficiently. Market is the most efficient mechanism for allocating resources. Reducing the role of Government, which advocates health care for all, would make it possible for the market to separate allocation and distributional policies (Berki, 1983). Escalating health care costs is the most frequent reason given to local Government officials in seeking alternative approaches to public service delivery. They choose to reduce cost through outsourcing and or privatization. Fiscal factors are most important in determining choices to contract out services (Clingermayer & Fejock, 1997). Escalating costs and complexity have contributed to the decline in the number of public hospitals. Hospital management can also be done through forming special districts to run them. This approach may be attributed to public sector accountability and citizens’ opposition (Greene, 2002). Cost sharing involves transactions that have costs and benefits hence this theory is relevant.
Emphasizes that organizations are open systems strongly influenced by their environment (Scott, 1995). Selznick, the founder of institutional theory, noted that the most important thing about organizations is that each has a life of its own. To protect itself an organization will insulate itself and gain protection by standardizing work process.

IT seeks to explain variation among organizations during formation and their homogeneity once they become well established (Dimaggio & Powell, 1983). Organizations experience pressure to conform to their institutional environment due to political, occupational or professional constituencies (Brown & Potoski, 2003). The Governments in making service delivery choices in health sector, considers costs, the roles of hospitals in the community and survival as organizations.

Institutions have three pillars namely: regulative, normative and cognitive (Scott, 1995). Hospitals use these pillars since they have: one, rules, governance system and constitution. Two, have accreditation and certification. Three, have adaptation. Hospitals are redesigning structures and processes in order to maximize efficiencies and remain economically viable.
2.3 Empirical Review

Most Governments and donors have favoured the concept of Cost Sharing in Health and education sectors as an appropriate strategy. It was believed to be the only financially viable alternative that would enhance parent ownership of their children’s health and education. Several studies have been made on the impact of cost sharing on access, equity, efficiency, revenue generation, waiver and exemption hence this concept has become a subject of serious scrutiny and re-thinking. In Niger, Diop et al, (1995) conclude that for health services access to be achieved and sustained in rural areas, cost recovery should be accompanied by not only improvement in quality but also cost containment measures.

Many studies have sought to measure hospital efficiency using proxy measures such as hospital’s length of stay (LoS) for elective and emergency care (Gaynor et al, 2010).
A study of impact of hospital competition on providers’ efficiency found that absence of competitive pressure on public sector managers hinders the achievement of maximum possible level of efficiency (Leibenstein, 1966). Consequently managers of public sector organizations often lack the incentive to: limit waste of resources, make optimal use of resources, produce output in such a way that current needs are met.

In Australia, a study by Verhoeven et al (2007) on analysis of efficiency in public health spending in G7 countries found that a number of policy and institutional differences were associated with differences in efficiency. They found that: countries that spend a relatively large share of health budget on labour costs tend to be less efficient, immunizations and doctors’ consultations but not necessarily the number of doctors are positively correlated with greater efficiency and an increase in geographic concentration of health care professional leads to decrease in health sector efficiency.

Bamum and Kutzin (1993) indicated areas that planners and managers should focus on to improve efficiency of referral hospitals which include: reducing inappropriate outpatient and inpatient use of referral hospitals, improving systems to allow early discharge from hospital, ensuring that bed occupancy rates can be maintained as close as possible to optimal rates, adopting intelligent procurement processes and engaging in effective negotiations with suppliers in relation to prices and service levels and ensuring effective ordering, stock control and distribution systems to minimize theft and wastage of key supplies.

Focusing on Arizona hospitals 1989 – 1990. Burns et al, (1994) studied efficiency as defined by how far a patient’s length of stay and charges were below hospitals average. They found physicians’ characteristics had a significant impact on hospital efficiency. It has been suggested that Governments involvement in the provision of health care services has been a major contributory factor to the inefficiencies observed in public hospitals (World Bank, 1993) and thus a movement away from centralized decision making and provision of health care by the public sector has been recommended (World Bank, 1993).

In Kenya, the studies indicated a declining access to care (Collins et al, 1996). This justified the programme’s temporarily suspension in 1990.

Studies on user charges have shown that, the poor are relatively more sensitive to prices increases than the rich (Gertler & Vander Gaag, 1990). Mbugua (1993) further demonstrates that
household incomes strongly influence the choice of provider, with overall conclusion that user charges may impede access by the poor to possible quality care.

The use of utilization data to assess the impact of the user fees on access of health care services provides conflicting results. One, an increase in demand resulting from quality improvement. Two, migration of patients to private sector (Deolalikar, 1997). Three, reduction in the utilization of public services (Mwabu & Wang’ombe, 1995). Kimalu et al (2004) concluded that a price increase in Government health facilities has the effect of diverting demand to non-Government clinics, but it increases demand for self treatment by a negligible amount. This supports Sahn et al (2002) findings in Tanzania.

A RAND Study conducted by Manning & Newhouse in the 1970s analyzing the impact of user fees on access concluded that the higher prices led to decreased utilization of modern health care facilities especially by low income families. Many of the poor would exit the formal Medical Care Market in response to higher fees. Studies have also shown that user fees elicit household coping strategies. These include delaying or not seeking treatment, seeking informal care or self treatment (Sahn et al. 2003); Health services may be obtained at the expense of selling off assets, removing children from school, reducing food consumption or borrowing (Buchman, 1996).

In China, a study by Liu and Mills, 2002, shows that user fees reduced take up of preventive services. The increased reliance on user fees worsened allocative efficiency, with over-provision of unnecessary services and under-provision of socially desirable services.

However, if user fees are accompanied by improved quality, utilization increases (Litvack et al. 1993). Studies supported the notion that quality improvement can negate rising fees (Diop et al, 1995). In Tanzania, a study by Leonard, Mliga & Miriam, 2002 revealed that poor patients often by-pass low quality public health facilities in favour of those offering high quality services including better health assessment and prescriptions.

Effective exemption policies ensure that the poor have access to health care. Although many Governments designed the exemption policies, they were difficult to put in action (Kaddar et al, 1997). Administration costs were high and many countries had neither the capacity nor political will to put in place exemption policies (Watkins, 1997), systems were simply ineffective (Gilson et al, 1995). Exemptions were weakly linked to the poverty status of users .(Newbrander et al. 2000).
In Kenya only one percent to five percent of the users were exempted because of their poverty status, although eleven percent to thirty four percent of the population fulfilled the criteria for exemption (Huber, 1993). In a Multi-Country Study, fees were not waived among the poor because either they were unaware of such Waivers or Exemption System was not in place (Newbrander et al. 2000). Leakage also occurred such that non-eligible users were being exempted (Gilson et al, 1995).

Revenue from user fees supplements hospital income in public hospitals, hence these facilities have incentive to collect fees. Experience in African countries indicates that National User Fees System performs dismaly. It generates an average of five percent of total recurrent health system expenditure, gross of administrative costs (Gilson et al. 1995). This may cover a sizeable proportion of non-salary operating costs. Cost recovery has not proven to be a panacea for cash-strapped health system in poor countries. Certain countries are beginning to reverse the policy on cost recovery. Uganda removed its Cost Sharing program and supplemented the health budget with funds from World Bank Project (Burnham et al, 2004). Some argue that cost-recovery remain essential but must be done humanely (Vander Geest et al. 2000). Others argue that cost recovery is not the best policy for poor countries and that other financing mechanisms should be considered such as community health insurance (Arhin Tenkorang, 2001).

However, fees have been shown to be useful in improving some structural aspects of quality (drug availability, financial book keeping, improving patients’ perception of care or providing financial incentives to health workers when fees were reserved for use at the facility where fees were collected (Shaw & Ain Sworth, 1995).

2.3.1 Operationalization

Different countries have different cost sharing practices. Central African Republic has since 1991 adopted four different user schemes: a charge for service rendered, a flat rate for each episode of illness, a flat rate per visit and a prepayment for a year of service.

Successful prepayment schemes operate in Guinea Bissau and Zaire. In Guinea Bissau, villagers participate in prepayment scheme for drugs and basic service through annual collections made shortly after harvest when cash is available. In Zaire, annual collections for prepayment schemes for hospital services are made during the season when cash incomes are highest (World Bank, 19...
1996). In France, population is covered by statutory Occupation-based National Health Insurance Schemes that are part of the Social Security Systems.

The United States of America has three principal Public health insurance programs; Medicare, Medicaid, and Civilian health and Medical program of uniformed services and over one thousand private insurers each following different underwriting, benefits and reimbursement policies. The Government of Kenya (GOK) acknowledges that Kenyans are entitled to quality, accessible and affordable health care services.

At Independence in 1963, Kenya committed itself to provide free public education and health care. Cost sharing was not part of the policy discussion between 1965 and 1988, when financing was supported by general tax revenue. After two decades of free health care services, Kenya’s Health Sector was on the verge of collapse due to economic crisis of the late 1980’s. This led to introduction of Cost Sharing in 1989 to raise revenues in outpatient wards in hospitals and health centers to supplement Government health financing from other sources.

Cost Sharing program was one of the components of the APHIA Financing and Sustainability (AFS) project implemented by the Management Science for health with the support of the United State Agency for International Development (USAID).

In August 1989, the results of the discussion on cost-sharing, which took place between the Government of Kenya and its development partners (mainly donors), were put before the Kenyan cabinet, which basically endorsed the proposed system of health financing for the public sector.

The Ministry of Health expressed its fears about the introduction of user fees and complained to the World Bank that the proposed fees to be charged were high. The introduction of user fees also coincided with the introduction of multi-party politics in Kenya and this threatened the popularity of the ruling party KANU among the masses.

The opposition political parties took advantage of the introduction of user fees to challenge the government’s inability to provide ‘free’ health care services to its citizens. Generally, the government was not willing to introduce user fees and even after their introduction, revisions were continuously announced, mostly at public rallies, in order to rally the support of the masses. User fees charged on patients was deemed as low in the first instance, but the statistics regarding hospital attendance began to take a downward trend, prompting the president to intervene. The president called for a reduction from 100 to 20 Kenyan shillings per day at
Kenyatta National Hospital for in-patients (Dahlgren 1990). This was done after it was realized that the utilization of the hospital service had fallen drastically due to reasons related to affordability, and subsequently bringing to the fore the issue of accessibility. But despite all this, Ake (1996) asserts that ‘Africa still lost out as it continued complaining while implementing SAPs, imposed on these societies by the World Bank and the IMF as a condition for additional extension of credit’.

A system of waivers and exemptions was provided in the new policy to address the concern that the policy could not be affordable to the vulnerable who would in turn be denied access to modern health services. Initial beneficiaries of this system included children under five years, prisoners, the destitute and the mentally handicapped, patients attending family planning, antenatal and post natal care, child welfare, sexually transmitted diseases, psychiatric illnesses, tuberculosis, leprosy, AIDS, and patients referred ‘downward’ or ‘upward’ within the Ministry of Health system.

To operationalize Cost Sharing, a Facility Improvement Fund Operational Manual for Provincial General Hospitals, District Hospitals and Sub-District Hospitals was developed by the Ministry of Health (MOH). The manual was reviewed in 2002 and 2004 as need arose (M.O.H, 2004). The manual sets procedures, guidelines and financial regulations to be adopted in order to improve Cost Sharing revenue collection, management and use of Facility Improvement Fund (FIF) revenues. Specific instructions which vary over time such as fee level or exemption categories are not included in the manual, but are contained in MOH Circulars issued to hospitals (FIF Operation Manual MOH, 2002; FIF Operation Manual MOH, 2004; MOH Circular No. DHFC/Vol/(140) of 30.12.2004).

In Kenya total user fees collection have increased substantially over time from Kenya Shillings one billion and thirty three million in Financial Year 2002/2003 to Kenya Shillings one billion, eight hundred millions in the financial year 2008/2009 (Division of Health Care Financing Internal Statistics MOH, 2010).

The administration and planning of health care in MOH is carried out at four levels: Headquarters, Provincial, District and facility levels.
The headquarters set policies, co-ordinate activities and implementation of Government policies including Cost Sharing, Monitoring and evaluation of the impact of policy changes (Carrin, 2003).

Provincial level co-ordinates health care financing activities in their respective Provinces, trains District Health Management Team (DHMT), approving Cost Sharing Expenditure and Issue Authority to Incur Expenditure (A.I. Es).

District Level co-ordinates health activities in the District, review reports on collection, exemption and waiver performance responsible for fees collection, claiming National Hospital Insurance Fund (NHIF) and accounting for the same and maintaining quality health services.

Facility level is responsible for collecting fees, preparing and implementing facility level expenditure and maintaining quality services (FIF Operation Manual MOH, 2004; FIF Operation Manual MOH, 2002).

2.3.2 Management of Public Hospitals

The importance of governance role in health care cannot be underestimated due to the impact of the health care systems on human wellbeing, the size of this sector in the current economy and the increase to thirty percent of Gross Domestic Product (GDP) expected in Organisation For Economic Co-operation and Development (OECD) countries by 2030 (Boscheck, 2006).

Management of hospitals has been a major concern in many countries in recent years. It has been argued that public hospitals have low levels of efficiency (Preker & Hading, 2003). One policy response to this has been to seek to increase autonomy of Public hospitals (Mcpake, 1995). Management has been decentralized. It is hoped autonomy will provide incentives to improve efficiency.

There are three levels of management of hospitals: Hospital Management Boards, Hospital Management Teams and Functional Units (MOH, 2002).

Hospitals are run by Management Teams. The Boards monitor hospital operations, mobilize and administer funds, set exemption criteria for users of health services, review reports, monitor and verify cost sharing collection, expenditure and control of funds. The community is represented in these boards. Local community members should be involved in the collection and control of revenue for health care (Jakab & Krishnah, 2004). Shaw and Griffin (1995) stated that “Perhaps the ultimate goal of cost sharing should be to ensure that households and communities have a say
in the design and delivery of basic cost-effective services". However, a study by Chee, Smith et al (2002) concluded that communities had little participation in overall management of hospitals. At the national level, the Government has responsibility of monitoring, regulating and guiding the operations of community based health financing schemes (Carrin, 2003). The health management boards submit to the National Government; monthly, quarterly and annual reports. Health Management Team consists of Government representatives. It makes policy decision and carries out supervisory functions. Persistent challenges facing health care delivery system including inadequate funding and failure to assure basic health services to large segments of the population have also reinforced the importance of the role of Government and regulatory agencies as ‘stewards’ of the health care systems, setting priorities, establishing and changing laws and regulations and monitoring quality of care in the public and private sectors (Dmytraczenko et al, 2003). As well, hospital management services or the entire provision of hospital services can be contracted out to the private sector. United Kingdom Government has used Public-Private partnerships in financing construction and facility management for many public hospitals over the past decades.

2.3.3 Transparency and Accountability

The experience from (OECD) countries suggest that successful cost-sharing policies:

- Are transparent to all: Simple and easy to understand.
- Result in cost savings to the insurance or state general revenue funds
- Ensure that patients share in the cost of health care.
- Are administratively cost-effective, feasible and practical.
- Provide positive reinforcement for patients’ cost sharing behavior and encourage patients’ “cost-sensitivity” and “thoughtful” utilization of care (World Bank, 2008).

This study sought to establish whether the above policies are applied in the management and accounting for cost sharing funds. In addition, it sought to establish whether the Health Management Board has financial management skills.
2.3.4 Protection Policy- Exemptions and Waivers

These policies are designed to enhance access to services for the poor. They ensure no patient is denied essential health care due to inability to pay. These policies are a way to deal with negative impact of user fees on a particular client group.

The Government of Kenya in its goal to achieve equity introduced policy directive to exempt the poor (Wang’ombe et al, 2002). Services with public health benefits such as vaccinations would be exempt from fees to encourage people to use them. Policy on management of waivers and exemptions should be in place.

The ultimate objective of any health care financing system is “effective access to affordable health care services of adequate quality and financial protection in case of sickness”.

Key to the success of Waiver and Exemption System, is its financing. Systems that compensate providers for revenue foregone from granting Waivers and Exemption (e.g. Thailand. Indonesia and Cambodia) have been more successful than those who expect the provider to absorb the cost of exemptions such as Kenya (World Bank, 2004).

This study sought to establish whether the criteria set to identify the poor who qualify for waivers and exemptions is implemented and whether the National Government promptly finances the revenue gap as a result of waivers and exemptions.

2.3.5 Legal and Political Framework

The existence of relevant legislation and political support of cost sharing practices is necessary to give it a clear mandate and responsibility for its implementation. Absence of this framework is likely to pose a challenge to its implementation. This study sought to establish whether there exist a legal and political framework and its effect on successful implementation of cost sharing practices.

2.3.6 Limited Resources

Reforms implementation require resources in terms of funds, human capacity and working tools. Available resources must be used efficiently and equitably. Scarcity of resources demands serious policy making, planning, programming, budgeting and tighter co-ordination of activities. One of the reasons for introducing cost sharing fees/revenues was to cushion the impact of declining budget allocation to health facilities.
The Government need to focus more on the financing and delivery of health services. This study tried to establish whether resources provided by Government and generated through cost sharing are sufficient to the facility.

**Figure 2.2: Operational Framework**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Parameter</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful Implementation of Cost Sharing Practices</td>
<td>Management Factors</td>
<td>- Rules and procedures</td>
</tr>
<tr>
<td></td>
<td>Transparency and Accountability</td>
<td>- Competence</td>
</tr>
<tr>
<td></td>
<td>Protection Policy</td>
<td>- Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td></td>
<td>Legal and Political Framework</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited Resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Citizen participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Access to information (openness)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Compliance to financial control and management laws, rules and regulations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Public awareness.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Price structure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Number of waivers and exemptions granted.</td>
</tr>
</tbody>
</table>

Source: Author (2012)
2.4 Conceptualization

An efficient and equitable health care programme is an essential ingredient in the improvement of welfare of the population for any country. Good health is very important for economic growth, development and enjoyment of life by the population and achievement of Millennium Development Goals (MDGs).

World Health Organization (WHO) report 2000 noted that, “Health Systems provide the critical interface between life saving, life enhancing interventions and the people who need them. If health systems are weak, the power of these interventions is likewise weakened or even lost. Health Systems thus deserve the highest priority in any efforts to improve health or ensure that resources are wisely used” (WHO, 2000).

In Kenya, the programme has several key policy elements: To provide collection incentives and to ensure availability of extra funds, Cost Sharing would be additive to Government allocation and would be retained at local level and be spent according to certain official guidelines. To encourage efficient use, funds would not be used for capital works or staff but would be used for critical needs such as supplies and maintenance.

2.4.1 Management

Is getting things done through people. It involves the tasks of planning, organizing, directing, staffing and controlling resources towards achievement of set specific objective(s). This study will concentrate on these tasks of management that might challenge successful implementation of cost sharing practices in Public hospitals.

2.4.2 Transparency and Accountability

Accountability is being held responsible by others and taking responsibility for one’s actions. It involves both the political justification of decisions and actions and managerial answerability for implementation of agreed tasks according to agreed criteria of performance (Day & Klein, 1987). Transparency is the openness and communication of activities being undertaken. Public hospitals have become a target of local communities’ demand for transparency and accountability because of the central role they play in health care delivery. This study will establish whether lack of transparency and accountability will affect successful implementation of cost sharing practices in public hospitals.
2.4.3 Protection Policy

This is a health policy intended to protect individuals or groups from being denied health care services due to inability to pay. It ensures citizens have access to quality and affordable health care. It is in form of waivers and exemptions. Policies seeking to improve protection of the poor should streamline any bureaucracy involved in the reimbursement to facilities for exemptions and waivers granted.

2.4.4 Legal and Political Framework

Appropriate legislation (Appropriate Act of Parliament) supporting adoption and implementation of cost sharing practices is important. It should give clear mandate and responsibility for implementation. Political support is also required.

2.4.5 Limited Resources

Implementation of any reform requires extra resources such as funding, human resources and working tools/equipment. Cost sharing included. Sufficient resources need to be allocated for this purpose failure to which may hinder successful implementation of the reform.
2.5 Research Gap

The research concentrated on the best of cost sharing practices being implemented by public hospitals and challenges facing cost-sharing practices in Public hospitals in Kenya and was based on selected Public hospitals/facilities. Several studies have been made on the impact of cost-sharing on access, equity and cost-sharing revenue generation, none has been studied to evaluate the best cost sharing practices being implemented and challenges facing cost sharing practices in Public hospitals in Kenya. Hence this study bridged an evident research gap.
CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction
This chapter describes the methods, techniques and strategies that was used to answer the research problem. It gives a description of the research design, population, sampling techniques and data collection procedures that was used. It also describes the data analysis techniques used in the study.

3.2 Research Design
The study adopted the descriptive research design. A descriptive survey is a process of collecting data from the members of a population in order to determine the current status of the sample under study with respect to one or more variables. The major emphasis of a descriptive study is to determine the frequency of occurrence or the extent to which variables are related (Kothari 2005). This design was suitable because the study required an accurate evaluation of the cost sharing practices and challenges hindering successful implementation of Cost Sharing practices in public hospitals.

3.3 Target Population
A population is defined as the total collection of elements about which the researcher wishes to make some inferences. According to Field (2005), a population is a well defined or set of people, services, elements, events, group of things or households that are being investigated. This definition ensures that population of interest is homogeneous. A population element is the subject such as a person, an organization, customer database, or the amount of quantitative data on which measurement is being taken, Cooper and Schindler, (2003). For the research work, study population consisted of all Provincial General Hospitals. and Referral hospitals registered in Kenya by December, 2010. According to Ministry of Health they were ten.
Table 3.1: Target Population

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Public Hospitals (GoK)</td>
</tr>
<tr>
<td>Provincial General Hospitals</td>
<td>7</td>
</tr>
<tr>
<td>Referral Hospitals</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>10</td>
</tr>
</tbody>
</table>

3.4 Sampling Design and Sample Size

3.4.1 Sampling Techniques

According to Mugenda & Mugenda, (2003), sampling is the process of selecting a number of individuals for a study in such a way that the individuals selected represents the large group from which they are selected. Chandran, (2003) defines a sample as a small proportion of an entire population; a selection from the population.

Sampling is the process of constructing or designing a sample and begins by defining the sampling frame. Sampling technique was applied in this study. Two referral hospitals were randomly selected and all the seven Provincial General Hospitals were selected for the study. This enhanced representativeness of the data collected and generation of the study findings. The number of selected respondent was based on the representation of three per selected hospital.

3.4.2 Sample Size

The sample size of nine Public hospitals was selected. The selection of sample size depends on various factors. These factors included size of target population, statistical method in use, primary variables of measurement and limitations of data collection (babbie, 1989). It should bear some proportional relationship to the size of the population from which it is drawn. The sample size was based on hundred percent of PGHs and sixty seven per cent of the referral hospitals.
### Table 3.2 Population Distribution of Public Health Facilities

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Target</th>
<th>Sample Size</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial General Hospital</td>
<td>7</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Referral Hospitals</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>10</strong></td>
<td><strong>9</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

#### 3.5 Data Collection

Data is a piece of information that helps to analyze and appraise the given problem in a research study. It could either be primary data which is collected individually or secondary data that is obtained from already existing source.

Structured questions was used to collect data from the respondents. With semi structured questions, the respondents were able to give insight information on cost sharing practices in the public hospitals. Questionnaires allowed greater uniformity in the way questions were asked, ensuring greater compatibility in the responses. A five point non-comparative Likert scale was used for the closed ended questions, the intent of the Likert is that the statement represented different aspects of the same attitude (Brace 2004).

The data for the research study was collected from the respondents who for provincial hospitals were the Provincial Medical Officer of Health, Hospital Administrators and Accountants-In-charge whereas for referral hospitals Chief Executive Officer/Director, Chief Accountant and Medical Officer-In-Charge were considered. Secondary data was sourced from library materials and Ministry of Health Publications.
Permission to conduct the study was obtained from the relevant authority and the respondents were sensitized on the research exercise at least a week in advance. The researcher hired two research assistants during the study.

3.6 Data Analysis and Reporting

The data analysis for this study was based on quantitative approach using descriptive and inferential statistics. The data was analyzed with the help of statistical package for Social Sciences (SPSS) version. Percentages, frequencies, pie charts, tables and graphs were used where applicable to facilitate easy understanding. Multiple regression analysis was used to evaluate the statistical reliability of the following model.

\[ Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + E \]

Where

- \( Y = \) Successful Implementation of Cost Sharing practices in Public hospitals.
- \( E = \) Unexplained Variation i.e error term.
- \( \beta_0 = \) Constant. It defines value of successful implementation of Cost Sharing practices without inclusion of predictor variables.
- \( \beta_1, \beta_2, \beta_3, \beta_4, \beta_5, = \) Regression Co-efficient. Define the amount by which \( Y \) is changed for every unit change of predictor variables.

The significance of each of the co-efficient was tested at 95 percent level of confidence to explain the variable that explains most of the problem.
4.0  DATA ANALYSIS AND INTERPRETATION

4.1  Introduction

This chapter presents the quantitative analysis of data collected from the respondents. The chapter gives the findings from the questionnaires and other observations that were encountered during the study. The data has been categorically analyzed to give clear and vivid findings of the study. The study targeted a total of Twenty Seven respondents, there was 96.3% response rate since Twenty Six respondents filled and returned the questionnaires.

4.2  Demographic information of the respondents

Figure 4.1: Respondents Gender

The findings on figure 4.1 shows that among the respondents, the majority were male at 63.4% while female respondents were 36.6%. The findings imply that there was low female representation in the hospital boards and other cadres where questionnaires were administered.
Table 4.1: Education levels of the respondents

<table>
<thead>
<tr>
<th>Education level</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Secondary</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Diploma</td>
<td>4</td>
<td>15.3</td>
</tr>
<tr>
<td>Degree</td>
<td>22</td>
<td>84.7</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Results on table 4.1 show the education levels attained by the respondents, a greater proportion of the respondents 22(84%) had university degrees while 4(15.3%) had Diplomas. This implies that the researcher targeted well informed respondents and therefore they gave accurate and relevant information concerning cost sharing practices in public hospitals.

Table 4.2: Respondents’ level of management

<table>
<thead>
<tr>
<th>Level of management</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Management</td>
<td>8</td>
<td>30.8</td>
</tr>
<tr>
<td>Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Management</td>
<td>12</td>
<td>46.2</td>
</tr>
<tr>
<td>Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional Unit</td>
<td>6</td>
<td>23.0</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The researcher sought to establish the level of management of the respondents, form the findings on table 4.2. A greater proportion of the respondents 12(46.2%) indicated that they are in hospital management board. 8(30.8%) were in the hospital management team while 6(23.0%) were in the functional unit.

4.3 Cost sharing practices

Figure 4.2: Cost sharing department

The researcher sought to find out if the hospitals had departments responsible for cost sharing, from the findings on figure 4.2. 73.4% indicated that there were departments responsible for cost sharing, 26.6% however declined. The findings on figure 4.2 imply that most public hospitals have put in place cost sharing departments in order to improve cost sharing practices.
Table 4.3: Health Management Board

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are properly inducted to their duties</td>
<td>4.557</td>
<td>0.674</td>
<td>26</td>
</tr>
<tr>
<td>Understand the extent of their personal Liability for the affairs of the hospital</td>
<td>4.740</td>
<td>0.545</td>
<td>26</td>
</tr>
<tr>
<td>Have Financial and Accounting Knowledge to handle cost sharing implementation.</td>
<td>3.580</td>
<td>0.973</td>
<td>26</td>
</tr>
<tr>
<td>Hold regular formal Board Meetings</td>
<td>3.875</td>
<td>0.872</td>
<td>26</td>
</tr>
<tr>
<td>Board Meetings are conducted in a manner that encourages open communication, meaningful participation and timely resolution of issues</td>
<td>2.445</td>
<td>0.892</td>
<td>26</td>
</tr>
<tr>
<td>Health Management Board (HMB) Monitors cost sharing operation and cost sharing funds utilization</td>
<td>4.584</td>
<td>0.565</td>
<td>26</td>
</tr>
</tbody>
</table>

The researcher sought to establish the effect of certain factors related to health management boards on Successful Implementation of Cost Sharing practices in Public hospitals. The respondents were requested to respond to the statements on a 5 point Likert scale and indicate the extent they agree with the statements that is: 5-Strongly agree, 4-Slightly Agree, 3-Not Opinion, 2- Slightly Disagree, 1 -Strongly Disagree. A mean (M) score of 0-1.5 means that the respondents strongly disagreed, between 1.50 to 2.50 means they slightly disagreed, 2.50 to 3.50 means the respondents had no opinion, 3.50-4.50 means they slightly agreed, and a mean above 4.50 means the respondents strongly agreed. From the findings on table 4.3, the respondents strongly agreed with the following statements: Are properly inducted to their duties (M=4.557; SD=0.674), Understand the extent of their personal Liability for the affairs of the hospital (M=4.740; SD=0.545), Health Management Board (HMB) Monitors cost sharing operation and cost sharing funds utilization (M=4.584; SD=0.565). The respondents slightly agreed on the following statements: Have Financial and Accounting Knowledge to handle cost sharing...
implementation (M=3.580; SD=0.973), and that the boards holds regular formal Board Meetings (M=3.875; SD=0.872). The respondents however slightly disagreed that Board Meetings are conducted in Manner that encourages open Communication, meaningful Participation and timely resolution of Issues (M=2.445; SD=0.892).

**Table 4.4: Transparency and accountability**

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected funds are fully utilized and None remain idle in the bank Accounts.</td>
<td>3.452</td>
<td>0.704</td>
<td>26</td>
</tr>
<tr>
<td>There is no Mismanagement of Funds.</td>
<td>2.470</td>
<td>0.945</td>
<td>26</td>
</tr>
<tr>
<td>Regular audit of fund is conducted by Auditor General and Internal Auditors.</td>
<td>3.542</td>
<td>0.875</td>
<td>26</td>
</tr>
<tr>
<td>MB monitors and makes verification on collection, Expenditure and control of funds.</td>
<td>4.795</td>
<td>0.767</td>
<td>26</td>
</tr>
<tr>
<td>Ministry of Health Headquarters monitors Collection.</td>
<td>4.645</td>
<td>0.639</td>
<td>26</td>
</tr>
<tr>
<td>Health care staff are involved in Decision making regarding use of collected funds.</td>
<td>2.476</td>
<td>0.345</td>
<td>26</td>
</tr>
<tr>
<td>Collection of cost sharing fund has been enhanced by registers.</td>
<td>4.596</td>
<td>0.794</td>
<td>26</td>
</tr>
<tr>
<td>Close Supervision at facility Level by Health Management Administrative Staff has Enhanced accountability.</td>
<td>4.798</td>
<td>0.674</td>
<td>26</td>
</tr>
<tr>
<td>Community members are aware Of cost sharing fees</td>
<td>2.374</td>
<td>0.324</td>
<td>26</td>
</tr>
</tbody>
</table>
The researcher sought to establish the impact of transparency and accountability on Successful Implementation of Cost Sharing practices in Public hospitals. The respondents were requested to respond to the statements on a 5 point Likert scale and indicate the extent they agree with the statements that is: 5-Strongly agree, 4-Slightly Agree, 3-Not Opinion, 2- Slightly Disagree, 1- Strongly Disagree. A mean (M) score of 0-1.5 means that the respondents strongly disagreed, between 1.50 to 2.50 means they slightly disagreed, 2.50 to 3.50 means the respondents had no opinion, 3.50-4.50 means they slightly agreed, and a mean above 4.50 means the respondents strongly agreed. Based on the findings on table 4.4, the respondents strongly agreed with the following statement: MB monitors and makes verification collection Expenditure and control of funds (M=4.795;SD=0.767). Ministry of Health Headquarters monitors Collection (M=4.645;SD=0.639) and Collection of cost sharing fund has been enhanced by registers (M=4.596;SD=0.794). The respondents however slightly disagreed with the following statements: Health care staff are involved in decision making regarding use of collected funds. (M=2.476;SD=0.345) and Community members are aware Of cost sharing fees (M=2.374;SD=0.324).

**Figure 4.3: Citizen Participation in cost sharing**

The researcher sought to examine citizen participation in cost sharing process, based on the results on figure 4.3, 65% of the respondents considered citizen participation to be adequate while 26% considered it inadequate. The findings imply that citizen indeed participate in the cost sharing implementation process in the public hospitals.
<table>
<thead>
<tr>
<th>Protection policy</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A policy for waivers and Exemptions is in place</td>
<td>4.451</td>
<td>0.674</td>
<td>26</td>
</tr>
<tr>
<td>Community members are aware of its existence</td>
<td>2.370</td>
<td>0.345</td>
<td>26</td>
</tr>
<tr>
<td>Community members are aware of the procedure of seeking Waivers and exemptions</td>
<td>2.242</td>
<td>0.573</td>
<td>26</td>
</tr>
<tr>
<td>User fees structure is known to Community members</td>
<td>3.985</td>
<td>0.372</td>
<td>26</td>
</tr>
<tr>
<td>The price structure facilitates Access for the poor</td>
<td>2.945</td>
<td>0.892</td>
<td>26</td>
</tr>
<tr>
<td>Penalties are imposed on those Cheating the system</td>
<td>2.484</td>
<td>0.565</td>
<td>26</td>
</tr>
<tr>
<td>Agents responsible for providing Waivers actively screen the Potential beneficiaries</td>
<td>2.456</td>
<td>0.580</td>
<td>26</td>
</tr>
<tr>
<td>Identifying patients who qualify for waivers is difficult and takes long</td>
<td>4.692</td>
<td>0.784</td>
<td>26</td>
</tr>
<tr>
<td>No patient is denied health care Services due to inability to pay</td>
<td>4.874</td>
<td>0.238</td>
<td>26</td>
</tr>
<tr>
<td>There exist an effective system for recording and reporting waiver and exemptions</td>
<td>4.630</td>
<td>0.342</td>
<td>26</td>
</tr>
<tr>
<td>A monthly ceiling has been set For the maximum number of Waivers/exemption that can be Granted in a hospital/healthy Facility</td>
<td>4.770</td>
<td>0.537</td>
<td>26</td>
</tr>
<tr>
<td>Government promptly finances Revenues lost due to waiver Exemptions</td>
<td>4.630</td>
<td>0.545</td>
<td>26</td>
</tr>
</tbody>
</table>

The researcher sought to establish the impact of protection policy on Successful Implementation of Cost Sharing practices in Public hospitals. The respondents were asked to respond to the statements on a 5 point Likert scale and indicate the extent they agree with the statements that is: 5-Strongly agree, 4-Slightly Agree, 3-No Opinion, 2- Slightly Disagree, 1-Strongly Disagree.
The respondents strongly agreed with the following statements: A policy for waivers and exemptions is in place (M=4.451; SD=0.674), Identifying patients who qualify for waivers is difficult and takes long (M=4.692;SD=0.784), No patient is denied health care Services due to inability to pay (M=4.874;SD=0.238), There exist an effective system for recording and reporting waiver and exemptions (M=4.630;SD=0.342), A monthly ceiling has been set for the maximum number of Waivers/exemption that can be Granted in a hospital/healthy Facility (M=4.770;SD=0.537) and Government promptly finances Revenues lost due to waiver Exemptions (M=4.630;SD=0.545). The respondents however slightly disagreed with the following statements: Community members are aware of it existence (M=2.370;SD=0.573), Community members are aware of the procedure of seeking Waivers and exemptions (M=2.242;SD=0.573), The price structure facilitates access for the poor (M=2.945;SD=0.892), Penalties are imposed on those cheating the system (M=2.484, SD=0.565), and Agents responsible for providing Waivers actively screen the Potential beneficiaries (M=2.456; SD=0.580).

Table 4.6: Cost sharing implementation flows

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Sharing operation manual</td>
<td>4.552</td>
<td>0.474</td>
<td>26</td>
</tr>
<tr>
<td>Ministry has issued a standardized Template to ensure uniformity of reports from the health Facilities</td>
<td>4.870</td>
<td>0.275</td>
<td>26</td>
</tr>
</tbody>
</table>

The respondents were asked to indicate whether they agree on how information relating to the cost sharing information flows from and to the lead agents. The findings on table 4.6 revealed that the respondents strongly agree with the statements: Cost Sharing operation manual (M=4.552; SD=0.474) and Ministry has issued a standardized Template to ensure uniformity of reports from the health Facilities (M=4.870; SD=0.275).
Table 4.7: Legal and political

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is sufficient political Commitment and top Management support</td>
<td>4.652</td>
<td>0.674</td>
<td>26</td>
</tr>
<tr>
<td>There is sufficient supporting Legislative framework</td>
<td>2.470</td>
<td>0.745</td>
<td>26</td>
</tr>
<tr>
<td>Sustainable institutional Structure in place</td>
<td>4.542</td>
<td>0.973</td>
<td>26</td>
</tr>
<tr>
<td>There is co-ordination among Stakeholders on implementation</td>
<td>3.785</td>
<td>0.672</td>
<td>26</td>
</tr>
<tr>
<td>Health personnel support it</td>
<td>3.945</td>
<td>0.892</td>
<td>26</td>
</tr>
</tbody>
</table>

The respondents were asked the extent to which they agree with certain legal and political related factors. Based on the results on table 4.7, the respondents strongly agreed that: There is sufficient political Commitment and top Management support (M=4.652;SD=0.674) and that sustainable institutional Structure is in place (M=4.542;SD=0.973). They slightly agreed that There is co-ordination among Stakeholders on implementation (M=3.785;SD=0.672) and that Health personnel support it (M=3.945;SD=0.892). The respondents however slightly disagreed that there is sufficient supporting Legislative framework (M=2.470;SD=0.745).
Table 4.8: Limited resources

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue generated is used within the collecting facility</td>
<td>4.554</td>
<td>0.674</td>
<td>26</td>
</tr>
<tr>
<td>Revenue generated is efficiently used</td>
<td>3.878</td>
<td>0.445</td>
<td>26</td>
</tr>
<tr>
<td>Good management practices have led to increased cost sharing revenue collection</td>
<td>3.542</td>
<td>0.973</td>
<td>26</td>
</tr>
<tr>
<td>Revenue generated is used as an addition to hospitals budget allocation</td>
<td>3.785</td>
<td>0.872</td>
<td>26</td>
</tr>
<tr>
<td>Government budget allocation to hospital has not reduced with introduction of cost sharing</td>
<td>4.845</td>
<td>0.892</td>
<td>26</td>
</tr>
<tr>
<td>Systems have been established to ensure that cost of implementing cost sharing is minimized</td>
<td>2.484</td>
<td>0.565</td>
<td>26</td>
</tr>
<tr>
<td>Cost sharing revenue generated normally exceeds cost incurred in implementing cost sharing</td>
<td>2.456</td>
<td>0.784</td>
<td>26</td>
</tr>
<tr>
<td>There is an accounting information system</td>
<td>3.892</td>
<td>0.604</td>
<td>26</td>
</tr>
<tr>
<td>Information Communication Technology (ICT equipment are in use)</td>
<td>2.474</td>
<td>0.634</td>
<td>26</td>
</tr>
<tr>
<td>Employees are trained to use the ICT Equipment</td>
<td>3.530</td>
<td>0.543</td>
<td>26</td>
</tr>
<tr>
<td>Hospital employees have been trained on cost sharing practice</td>
<td>3.636</td>
<td>0.745</td>
<td>26</td>
</tr>
</tbody>
</table>

The researcher sought to determine the effects of limited resources on successful implementation of cost sharing practices in Public hospitals. The respondents were requested to respond to the statements on a 5 point Likert scale and indicate the extent they agree with the statements that is: 5-Strongly agree, 4-Slightly Agree, 3-No Opinion, 2-Slightly Disagree, 1-Strongly Disagree. The respondents strongly agreed with the following statements: Revenue generated is used within the collecting facility (M=4.554;SD=0.674) and Government budget allocation to
hospital has not reduced with introduction of cost sharing (M=4.845;SD=0.892) The respondents slightly agreed that: Revenue generated is efficiently used (M=3.878;SD=0.445), Good management practices have led to increased cost sharing revenue collection (M=3.542;SD=0.973), Revenue generated is used as an addition to hospitals budget allocation (M=3.785;SD=0.872), There is an accounting information system (M=3.892;SD=0.604) employees are trained to use ICT equipment (M=3.530;SD=0.543) and that Hospital employees have been trained On cost sharing practice (M=3.636;SD=0.745). The respondents however slightly disagreed with the following statements: Systems have been established to ensure that cost of implementing cost sharing is minimized (M=2.484;SD=0.565) and Information Communication Technology (ICT) equipment are in use (M=2.474; SD=0.634) and Cost Sharing generated normally exceeds cost incurred in implementing cost sharing (M=2.456;SD=0.784).

Figure 4.4: Challenges in cost sharing implementation process

![Challenges in cost sharing implementation practices](image-url)
The findings on figure 4.4 show that the public hospitals experience challenges in the implementation of cost sharing practices, this was cited by 72.4% of the respondents. The challenges cited by the respondents included: Poverty in communities that increases waivers, difficulty in determining the patients who qualify for waivers, inadequate budget allocation by the government, failure by the government to promptly reimburse the hospitals for costs forfeited through protection policy, inadequate staff to run the funds and that board members are not well trained on financial management and accounting.

Figure 4.5: Flow of information

![Flow of information graph](image)

The respondents were asked on the medium they consider relevant to improve the information flow between the citizens and the cost sharing implementing agencies. Based on the findings on figure 4.5, a greater proportion (45%) of the respondents consider television scripts as the most relevant medium while 26% cited pamphlets.
4.4 Regression analysis

The researcher performed a regression analysis to establish the association between the independent variables with the dependent variable.

\[ y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \varepsilon \]

Where:

- \( Y \) = Successful Implementation of Cost Sharing practices in Public hospitals.
- \( X_1 \) = Management
- \( X_2 \) = Accountability and Transparency
- \( X_3 \) = Protection Policy
- \( X_4 \) = Legal and Political
- \( X_5 \) = Limited Resources

\( \beta_0 \) = Constant. It defines value of successful implementation of Cost Sharing practices without inclusion of predictor variables.

\( \beta_1, \beta_2, \beta_3, \beta_4, \beta_5 \) = Regression Co-efficient. Define the amount by which \( Y \) is changed for every unit change of predictor variables.

\( \varepsilon \) = Std. Error of the Estimate

4.5 Strength of the model

Analysis in table 4.8 shows that the coefficient of determination (the percentage variation in the dependent variable being explained by the changes in the independent variables) \( R^2 \) equals 0.843, Management, Accountability and Transparency, Protection Policy, Legal and Political, Limited Resources leaving only 15.7 percent unexplained. The P-value of 0.000 (Less than 0.05) implies that the model of Successful Implementation of Cost Sharing practices in Public hospitals is significant at the 5 percent level of significance.
Table 4.9: Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of the Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.896a</td>
<td>.843</td>
<td>.974</td>
<td>2.04756</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Predictors: (Constant), Management, Accountability and Transparency, Protection Policy, Legal and Political, Limited Resources leaving

ANOVA

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>4</td>
<td>23.286</td>
<td>79.730</td>
<td>.000a</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>56</td>
<td>.292</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Management, Accountability and Transparency, Protection Policy, Legal and Political, Limited Resources leaving


Source: Research data 2012

ANOVA findings (P-value of 0.00) in table 4.9 show that there is correlation between the predictor's variables (Management, Accountability and Transparency, Protection Policy, Protection Policy, Limited Resources leaving) and response variable (Successful Implementation of Cost Sharing practices in Public hospitals). An F ratio is calculated which represents the variance between the groups, divided by the variance within the groups. A large F ratio indicates that there is more variability between the groups (caused by the independent variable) than there is within each group, referred to as the error term.
### Table 4.10: Coefficients of regression equation

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>.360</td>
<td>.068</td>
<td>.930</td>
<td>.354</td>
</tr>
<tr>
<td>Management</td>
<td>.946</td>
<td>.067</td>
<td>.297</td>
<td>3.798</td>
</tr>
<tr>
<td>Accountability and Transparency</td>
<td>.838</td>
<td>.070</td>
<td>.188</td>
<td>3.290</td>
</tr>
<tr>
<td>Protection Policy</td>
<td>.893</td>
<td>.062</td>
<td>.013</td>
<td>.215</td>
</tr>
<tr>
<td>Legal and Political</td>
<td>.957</td>
<td>.067</td>
<td>.406</td>
<td>5.445</td>
</tr>
<tr>
<td>Limited Resources</td>
<td>.634</td>
<td>.045</td>
<td>.320</td>
<td>.345</td>
</tr>
</tbody>
</table>


*Source: Research data 2012*

The established multiple linear regression equation becomes:

\[ Y = 0.360 + 0.946X_1 + 0.838X_2 + 0.893X_3 + 0.957X_4 + 0.634X_5 + 2.04756 \]

**Where**

Constant = 0.360, this implies that without cost the variables (Management, Accountability and Transparency, Protection Policy, Legal and Political Systems, Limited Resources leaving), the level Successful Implementation of Cost Sharing practices in Public hospitals would be 0.360.

\( X_1 = 0.946 \), implies that one unit change in Management results in 0.946 units increase in service delivery.

\( X_2 = 0.838 \), implies that one unit change in Accountability and Transparency results in 0.838 units increase in Successful Implementation of Cost Sharing practices in Public hospitals.

\( X_3 = 0.893 \), implies that one unit change in Protection Policy results in 0.893 units increase in Successful Implementation of Cost Sharing practices in Public hospitals.

\( X_4 = 0.957 \), implies that one unit change in Legal and Political systems results in 0.957 units increase in Successful Implementation of Cost Sharing practices in Public hospitals.
implies that one unit change in Limited Resources results in 0.634 units increase in Successful Implementation of Cost Sharing practices in Public hospitals.
CHAPTER FIVE

5.0 SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a discussion of the findings based on the data analyzed in chapter four, the conclusions of the study are drawn and recommendations made. The chapter also suggests areas for further research.

5.2 Summary of the findings

The findings of the study revealed that the respective public hospital management boards are properly inducted to their duties (M=4.557; SD=0.674), understand the extent of their personal liability for the affairs of the hospitals (M=4.740; SD=0.545), monitor cost sharing operation and cost sharing funds utilization (M=4.584; SD=0.565). However, board Meetings in the public hospitals are not conducted in manner that encourages open Communication, meaningful Participation and timely resolution of issues (M=2.445; SD=0.892).

Concerning transparency and accountability, the respondents strongly agreed that the management boards monitor and make verification on collection, expenditure and control of funds (M=4.795; SD=0.767), Ministry of Health Headquarters monitors Collection (M=4.645; SD=0.639) and Collection of cost sharing fund has been enhanced by registers (M=4.596; SD=0.794).

The findings revealed that a policy for waivers and Exemptions is in place (M=4.451; SD=0.674), Identifying patients who qualify for waivers is difficult and takes long (M=4.692;SD=0.784), No patient is denied health care Services due to inability to pay (M=4.874;SD=0.238), There exist an effective system for recording and reporting waiver and exemptions (M=4.630;SD=0.342), A monthly ceiling has been set for the maximum number of Waivers/exemption that can be Granted in a hospital/health Facility (M=4.770;SD=0.537) and Government promptly finances Revenues lost due to waiver Exemptions (M=4.630;SD=0.545).

On political and legal related factors, the findings of the study revealed that there is sufficient political commitment and top management support (M=4.652;SD=0.674) and that there is sustainable institutional structure in place (M=4.542;SD=0.973). Respondents however slightly
agreed that there is co-ordination among stakeholders on implementation (M=3.785;SD=0.672) and that Health personnel support it (M=3.945;SD=0.892) implying that stakeholders in the health sector have not coordinated to improve the cost sharing practices in public hospitals.

The findings further revealed that revenue generated is used within the collecting facility (M=4.554; SD=0.674), Government budget allocation to hospital has not reduced with introduction of cost sharing (M=4.845;SD=0.892) and Hospital employees have been trained on cost sharing practice (M=3.636;SD=0.745).

The respondents cited challenges in the implementation of cost sharing practices and from the findings the challenges included: Poverty in communities that increases waivers, difficulty in determining the patients who qualify for waivers, inadequate budget allocation by the government, failure by the government to promptly reimburse the hospitals for costs forfeited through protection policy, inadequate staff to run the funds and that board members are not well trained on financial management and accounting. Finally the regression results indicated a strong positive relationship between the dependent variable (Successful implementation of cost sharing practices in Public hospitals) and the independent variables (Management, Accountability and Transparency, Protection Policy, Legal and Political, Limited Resources leaving).

5.3 Conclusions

Based on the findings of the study, it can be concluded that the Successful implementation of cost sharing practices in Public hospitals is hindered by several challenges. Cost sharing is widely used in Kenyan health systems to moderate demand and/or raise revenue. However, the theoretical case for cost sharing is weak, particularly when applied to health services requiring referral or prescription. In practice it shifts costs to individuals and reduces the use of both appropriate and inappropriate health care, which has negative implications for equity and efficiency. Because cost sharing creates financial barriers to access, it should be accompanied by mechanisms to protect heavy users of health care and people in lower income groups. Exemption systems require administrative capacity and may generate significant transaction costs. Extensive exemptions combined with transaction costs limit the potential of cost sharing to raise revenue. There is little evidence to show that cost sharing is an effective means of containing costs.
Rather, cost sharing may encourage inefficient patterns of health care use. However, some forms of cost sharing—such as differential charges for pharmaceutical products—can be used to direct people away from the use of health care that is not cost-effective.

5.4 Recommendations

Based on the findings, it is recommended that the government should promptly fund the exemptions and waivers to reduce the constraints experienced by the public hospitals. The board members should be well trained in financial management and accounting to improve their efficiency. Budget allocation should be increased, and the village elders and the provincial administration officers should be involved in determining the patients who qualify for waiver and more staff should be hired. The government should employ qualified personnel and train existing ones to raise their capacities in order to affirm efficiency and proper utilization of resources and revenue maximization. Exemption systems should be designed from a clearly-defined notion of need and applied consistently. Differential charges can be used to encourage more cost-effective usage and efforts to contain costs should focus on health care supply rather than demand.

5.5 Limitations of the study

The major limitations of the study were:

- The data was collected from a small convenience sample. A study on a wider scale in public hospitals in other regions in Kenya may provide different results.

- Cost—Collecting data for analysis was costly in terms of time consumed and finances spent since it involved sending research assistants to all the provincial general hospitals and the two referral hospitals.

- Suspicion—At the initial stages of distributing the questionnaires, the target group was not free to fill the questionnaires. The researcher had to assure them that confidentiality was to be maintained and that the information given was to be used for research purposes only.
5.6 Suggestion for future research

Cost sharing is widely used health systems in Africa to moderate demand and/or raise revenue. However, the theoretical case for cost sharing is weak, particularly when applied to health care arising from referral or prescription. The following areas can be considered for future study: The extent to which cost sharing shifts costs to individuals and leads to significant reductions in the use of health care; the negative implications of cost sharing for equity and efficiency; differential charges that can be used to encourage more cost-effective patterns of health care use. Because cost sharing creates financial barriers to access, an evaluation of mechanisms that accompany it to protect heavy users of health care and lower income groups should be considered as an area of future research.
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Dear Respondent

RE: REQUEST TO FILL THE QUESTIONNAIRE FOR RESEARCH PURPOSES

This is to kindly request you to fill in the attached questionnaire for Master of Business Administration research purposes.

The research focuses on the best Cost Sharing Practices and challenges facing Cost Sharing practices in Public hospitals in Kenya with specific reference to selected Provincial General Hospitals, and referral hospitals. The information sought will be treated with utmost confidence, and the result of this study can be availed for your use or reference.

Thank you
Yours sincerely

George K. Gichuru

APPENDIX ii: RESEARCH QUESTIONNAIRE

You are kindly requested to frankly and honestly respond to the statements below by making (X) against any alternative which mostly apply to you.

Your responses will be kept strictly confidential and the information you give will only be used for the purpose of the research.

SECTION A (PERSONAL DATA)

1. Name: .................................................................................................. (Optional)

2. Profession: ...........................................................................................

3. Gender: □ Male □ Female

4. Age: □ Between 20 – 30 years

□31 – 40 years

□41 – 50 years

□51 – 60 years

□Above 60 years

60
5. Level of Education

□ Primary □ Diploma
□ Secondary □ Degree
□ Others (specify):

6. Which of the following levels of management do you belong?

□ Hospital Management Team
□ Hospital Management Board
□ Functional Unit
□ Others (specify)

SECTION B

Management

7. How many departments are there in your hospital/health facility?

8. Is there a separate department responsible for the management of cost sharing?

□ Yes □ No
9. If yes, what is the name of the department?

10. Is there a particular board responsible for reviewing cost sharing budget proposals from different departments?  □ Yes  □ No

If the answer to question 10 above is Yes, comment on the following statements using the scale from 1 to 5 (1-Strongly Agree 2- Slightly Agree 3- No opinion 4- Slightly Disagree 5-Totally Disagree) with respect to management of cost sharing practices.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>No Opinion</th>
<th>Slightly Disagree</th>
<th>Totally Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) There is adequate understanding and Commitment to the practices.</td>
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<td>(ii) Facility staff have financial and Management knowledge to handle Cost sharing implementation</td>
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<td>(iii) Has motivated health sector staff.</td>
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<tr>
<td>(iv) Community is involved in the Management of funds.</td>
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</tbody>
</table>
(v) Health Sector and District Treasury
Staff are clear on Management
Rules and procedures.
(vi) The practice is linked to Health Sector
Reforms.

12  **Health Management Board (HMB)**

(i) Does your health facility/hospital have a Health Management Board?
☐ Yes  ☐ No

(ii) If yes, how many members does it have? ...........................................

(iii) How are the Board Members selected? ..............................................

13 If the answer to question 12 (i) above is Yes, comment on the following statements using a scale from 1 to 5 (1-Strongly Agree 2- Slightly Agree 3- No opinion 4- Slightly Disagree 5- Totally Disagree) with respect to Board Members.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>No Opinion</th>
<th>Slightly Disagree</th>
<th>Totally Disagree</th>
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</table>

(i) Are properly inducted to their duties

(ii) Understand the extent of their personal Liability for the affairs of the hospital

(iii) Have Financial and Accounting Knowledge to handle cost sharing implementation.
(iv) Hold regular formal Board Meetings

(v) Board Meetings are conducted in a manner that encourages open communication, meaningful participation and timely resolution of issues.

(vii) Health Management Board (HMB) monitors cost sharing operation and cost sharing funds utilization.

Transparency and Accountability

14. Using the scale of 1 to 5 (where: 1-Strongly Agree 2- Slightly Agree 3- No opinion 4- Slightly Disagree 5- Totally Disagree) on the following areas of transparency and accountability of cost sharing funds respond to the following statements:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>No Opinion</th>
<th>Slightly Disagree</th>
<th>Totally Disagree</th>
</tr>
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<tbody>
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</tbody>
</table>

(i) Collected funds are fully utilized and none remain idle in the bank accounts.
(ii) There is no Mis-management of Funds.

(iii) Regular audit of fund is conducted
By Auditor General and Internal
Auditors.

(iv) MB monitors and make
Verification on collection,
Expenditure and control of funds.

(v) Ministry of Headquarters monitors
Collection.

(vi) Health care staff are involve in
Decision making regarding use
of collected funds.

(vii) Collection of cost sharing fund
Has been enhanced by registers.

(viii) Close Supervision at facility
Level by Health Management
Administrative Staff has
Enhanced accountability.

(ix) Community members are aware
Of cost sharing fees

15. Do you agree that the current citizen participation in the cost sharing implementation process is adequate?
16. If no adequate participation, how can this be improved to ensure full participation?

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

Protection Policy

17. Using a scale from 1 to 5 (1-Strongly Agree 2- Slightly Agree 3- No opinion 4- Slightly Disagree 5- Totally Disagree) on the following areas of Protection Policy (waivers and exemption) of cost sharing practices respond to statements below:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>No Opinion</th>
<th>Slightly Disagree</th>
<th>Totally Disagree</th>
</tr>
</thead>
<tbody>
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</table>

(i) A policy for waivers and Exemptions is in place

(ii) Community members are aware of
(iii) Community members are aware of the procedure of seeking Waivers and exemptions.
(iv) User fees structure is known to Community members.
(v) The price structure facilitate Access for the poor.
(vi) Penalties are imposed on those Cheating the system.
(vii) Agents responsible for providing Waivers actively screen the Potential beneficiaries.
(viii) Identifying patients who qualify For waivers is difficult and takes long.
(ix) No patient is denied health care Services due to inability to pay.
(x) There exist an effective system for recording and reporting waiver and exemptions.
(xi) A monthly ceiling has been set for the maximum number of waivers/exemption that can be granted in a hospital/healthy facility.

(xii) Government promptly finances revenues lost due to waivers exemptions.

18. Using the scale from 1 to 5 (1-Strongly Agree 2- Slightly Agree 3- No opinion 4- Slightly Disagree 5- Totally Disagree), indicate whether you agree on how information relating to the cost sharing implementation flows from and to the lead agent (Ministry of Health Headquarters) to and from the implementing hospital facilities.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>No Opinion</th>
<th>Slightly Disagree</th>
<th>Totally Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Sharing operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>manual</td>
<td></td>
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<tr>
<td>Ministry has issued a standized Template to ensure uniformity of reports from the health facilities.</td>
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</table>
To what extent do you agree or disagree with the following with respect to cost sharing implementation practices?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>No Opinion</th>
<th>Slightly Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) There is sufficient political commitment and top management support.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<td>(ii) There is sufficient supporting legislative framework.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>(iii) Sustainable institutional structure in place.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<td>(iv) There is co-ordination among stakeholders on implementation.</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>(v) Health personnel support it.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
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</table>
20. **Limited Resources**

With respect to Cost Sharing practices and using a scale of 1 to 5 (1-Strongly Agree 2-Slightly Agree 3-No opinion 4-Slightly Disagree 5-Totally Disagree) respond to the following statements:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>No Opinion</th>
<th>Slightly Disagree</th>
<th>Totally Disagree</th>
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</table>

(i) Revenue generated is used within the collecting facility.

(ii) Revenue generated is efficiently used.

(iii) Good management practices have led to increased cost sharing revenue collection.

(iv) Revenue generated is used as an addition to hospitals budget allocation.
(v) Government budget allocation to hospital has not reduced with introduction of cost sharing.

(vi) Systems have been established to ensure that cost of implementing cost sharing is minimized.

(vii) Cost sharing revenue generated normally exceeds cost incurred in implementing cost sharing.

(viii) There is an accounting information System.

(ix) Information Communication Technology (ICT) equipment are in use.

(x) Employees are trained to use the ICT Equipment.

(xi) Hospital employees have been trained on cost sharing practices.

21 Are there any other challenges faced in cost sharing implementation practices?

☐ Yes ☐ No
If answer to questions 21 is Yes, answer the following questions:

(i) Which are these additional challenges?

(ii) Recommend the proposed solutions to the above challenges.

Which of the following do you consider relevant to improve the information flow between the citizens and cost sharing Implementing Agencies.

- Advertisement press
- Television Scripts
- Pamphlets
- Baraza
- Other (Specify)