AN ANALYSIS OF THE USER-FEE POLICY FOR HEALTH CARE IN KENYA: IS THE EFFORT WORTH IT?

MWANGI P. K.

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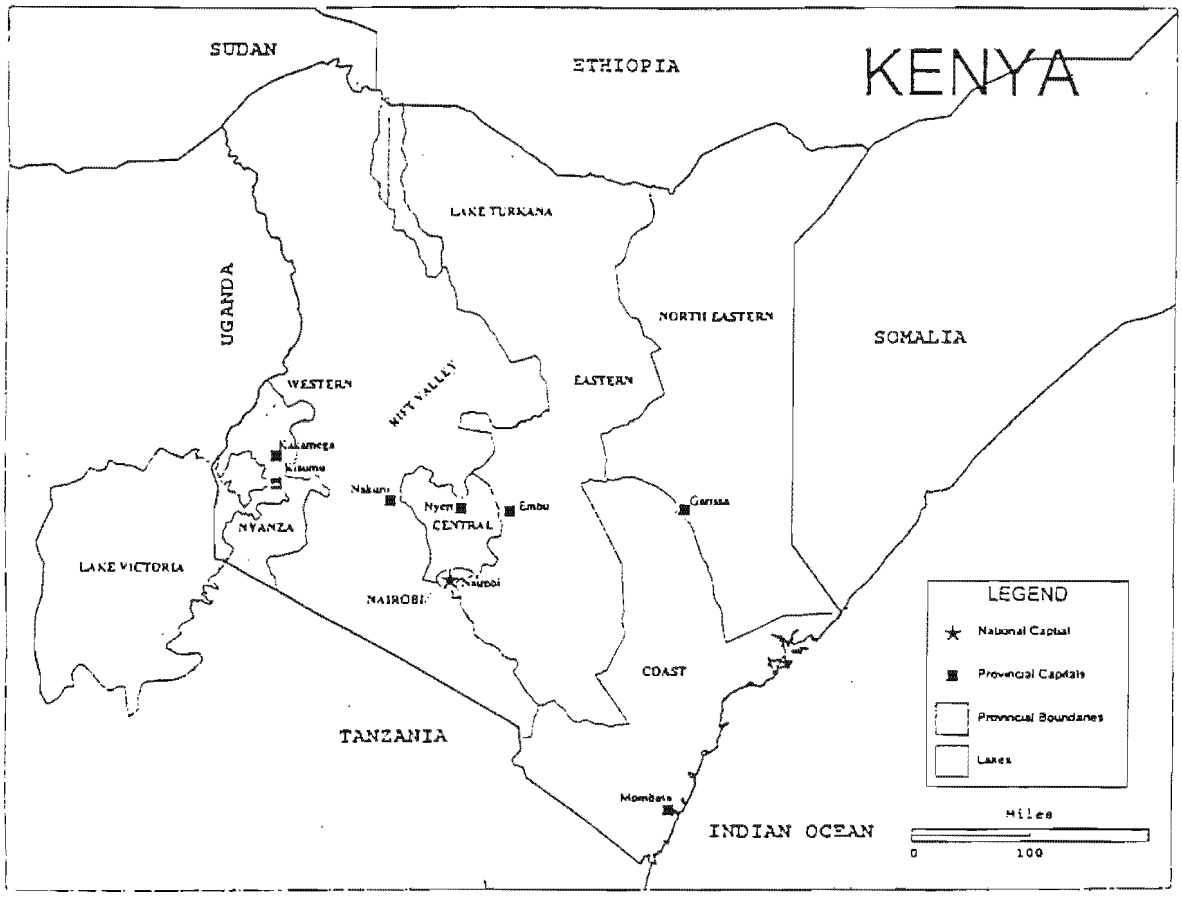
Dedication

To Wawira for her support and encouragement;

To Lars Block and Helena Perry of SIDA (Nairobi) for facilitating funding;

To Ministry of Health policy makers who desire to improve the health status of Kenyans; and

To public health workers devoted to providing quality and affordable care to the sick.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Nyeri
Embu
Garissa
Nairobi
Mombasa
LEGEND
National Capital
Provincial Capitals
Provincial Boundaries
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ABSTRACT.

This study analyses the user fee policy for health care in Kenya that was introduced to try and recoup some of the costs incurred in providing care as well as rationalise the use of resources. The study aims to generate policy-related findings that are crucial to MOH policy makers in their attempt to provide quality and affordable care. In particular, factors associated with proper function or malfunction of the user fee policy are discussed.

The study focussed on four hospitals located in Central province of Kenya. This province was purposefully chosen for its convenience and its high potential for cost recovery. Equity in health care consumption, efficiency, sustainability and perceived quality of care are reviewed. Both primary and secondary data were used. Quantitative and qualitative data were solicited by way of administering questionnaires. Respondents were divided into two categories: providers (staff) and consumers (patients) of health care. The latter were subdivided into inpatients and outpatients. Each of these categories had a specific questionnaire. Further, an attempt is made to estimate net revenue generated in the year 1997/98 by the facilities under study. Costs associated with fee collection were estimated on monthly basis and then projected for the whole year.

There are important findings from the study; though patients are charged higher fees at hospitals than at primary levels in order to bolster the referral system, many patients are bypassing the nearby primary care facilities. This study recommends that bypassing patients should be charged higher fees than referred ones. Currently,

all the patients are charged similar fees at hospital level irrespective of whether they are referred or not.

The user fee policy stipulated that equity would be promoted by offering exemptions and waivers, to try and protect those unable to pay or those who suffer a lot by paying. Patients are supposed to present a certificate of indigence issued by the local administration at the point of treatment. This study found out that this policy on exemptions and waivers was not communicated to the public through the mass media. At the facilities visited, many patients did not know that such a policy exists.

The study found out that MOH does not engage in continuous monitoring and supervision (auditing) of fee generation and expenditure. There is a need to streamline accountability and transparency in fee collection and usage in order to minimise pilferage. If directed, revenue generated can go a long way to improve the perceived quality of care and make user fees more acceptable and useful in health care provision. The study concludes that much remains to be done in order for the fee policy to be sustainable.

This study strongly recommends that similar research be conducted on a large scale, clearly indicating cost recovery ratios. Other alternatives or complementary options of health care financing should be examined for their feasibility, as MOH cannot fully rely on user fees only as a means of raising additional funds.

INTRODUCTION

1. Organisation of report.

In order to provide focus for the report, critical issues such as the statement of the problem, the significance of the study and the aim and objectives are defined in chapter one. It was also found useful to highlight limitations of the study here. Chapter two deals with the literature review. Here, the charging of user fees, one of Kenya's health care reform initiatives, is evaluated. In particular, ways of boosting cost recovery in public hospitals without sacrificing equity and efficiency in health care delivery are explored. Cost-effective ways of lowering morbidity and mortality rates in developing countries are also reviewed. Critical triggers of reforms in the health sector are discussed as well as the context in which reforms are implemented. The material is supplemented with field experiences in the implementation of user fees in Kenya. Chapter three deals with the country's health profile, in particular health care provision and financing. Chapter four maps out the study area with regard to its geographical, demographic, economic and health profile. Chapter seven deals with a description and evaluation of the report's methodology. Chapter eight deals with survey results and discussion. Here, the acceptability of the fee policy, perceived quality of care, exemptions and waivers, equity and utilisation patterns are discussed. This chapter concludes with estimation of cost-recovery ratios of the facilities under study. Recommendations and future challenges are highlighted in chapter nine.

1.1. Statement of the problem.

Kenya, like any other developing country, is faced with the problem of scarcity of resources to fully finance its health services. The government can no longer rely on conventional tax revenue to finance its health care. Considerable effort has been extended in trying to mobilise resources for health care, both from within the country and without. Among the reform policies promoted for mobilising additional resources is the implementation of user fees. Here, the patients pay a subsidised fee for the health services they consume, in an attempt by government to recover some of the costs incurred.

A key consideration when implementing an alternative source of health care finance is the level of net revenue that can be generated, and the potential for this revenue to increase in support of expanding health service provision (i.e. ensuring sustainability). It is imperative to distinguish between the gross revenue and the net revenue generated, i.e. to consider the disposable income available for health service once the costs of collecting and administering revenue have been deducted. Such costs may be critical, and this issue will be addressed in this study.

However, the user fee policy should not be blindly implemented without taking the poor into consideration, since they might be denied access. Further, for the fee policy to operate optimally, effective monitoring and supervision must be put into place. These are the reform challenges that continue to face the Kenyan government in its attempt to offer quality health services to her people. In this analysis, the challenges facing the user fee policy in Kenya will be highlighted and solutions suggested. It is important to bear in mind that experiences of user fee policy may be shared among the sub-Saharan countries, but

solutions cannot often be replicated as each country faces different problems, prospects and priorities.

1.2. Significance of the study

In a developing country like Kenya that is faced with a scarcity of resources and worsening of macro-economic performance, an analysis of user fee policy for health care is critical. User fees in Kenya have reduced public facility utilisation by over 35% (Mwabu *et al*, 1991). Those patients denied access to modern medical care are the poor who may have turned to other unregistered providers, or possibly may do without medication.

In some instances, the poor do pay for medication but at a great cost to their welfare. Due to inability to pay, many poor patients sell their valuable assets in an attempt to finance their health care. The knowledge of the net revenue generated, after the costs of collection have been taken into account, is important for policy makers. Further, close monitoring allows the deviations from the intended goals of the fee policy reform to be rectified in time, and measures put into place to ensure that the poor are not discriminated against. Such information allows them to decide if it is worth continuing to charge user fees or look for other sources of financing health care. This study examines economic costs of the user fee policy incurred so that the actual net revenue generated is documented from an economist's point of view (i.e. taking into account direct and indirect costs incurred). The findings of this study on issues of equity, utilisation patterns, efficiency, acceptability and sustainability of the program, will go a long way in seeing the weaknesses of fee policy and recommending appropriate action(s). The fact that no studies assessing the net revenue generated

by hospitals have been conducted in Kenya alone makes this undertaking worthwhile.

1.3. Aim and Objectives.

1.3.1. Aim

The aim of this study is to generate policy-related findings that will deepen the understanding of the factors associated with proper functioning or malfunctioning of the user fee policy in Central Province of Kenya. It tries to assess the usefulness of the scheme and its implications in light of the broad objectives of social and health policy: equity and efficiency. Further, the effects of user fees on acceptability, utilisation, sustainability and perceived quality of care are reviewed.

1.3.2. Specific objectives.

The specific objectives of this study are: to

1. Assess the financial sustainability and acceptability of the program to the various stakeholders (patients, providers, etc.).
2. Review the equity impact of the exemption policy both in theory and in practice.
3. Estimate the cost-recovery ratio of the program.
4. Assess the impact of fees on facility utilisation and perceived quality of care.

1.4. Limitations of the study.

The study uses both facility-based surveys and secondary data in a particular province in Kenya. It tries to analyse the user fee policy that has been in existence since December 1989. The study is particularly confined to investigating in detail the policy design, implementation and effects of user fee policy from the perspective of key stakeholders, such as patients and medical staff in Central province. Thus one needs to be wary of the fact that this study does not cover the entire country. Care should be taken in generalising the study findings to the entire country. In addition, shortcomings of the secondary data should not be overlooked. Particular shortcomings of this study are listed below:

1. Primary survey data were collected in the Central province of Kenya that is generally better off economically than others. The study therefore does not take into account the socio-economic diversity that may exist within the country.

2. The primary data were collected via facility-based surveys in public facilities. Thus it does not take into account the views of patients or of medical staff from the private facilities (private-for-profit and private-not-for-profit), or of those patients who sought no health care.

3. The in-patient and outpatient interviews involved people who were sick at the time of interview. Thus, elicitation of reliable responses on the spot from ill people was difficult, especially in case of in-patients. This may have affected the quality of the data.

4. Primary data is generated by means of survey instruments that largely collect opinions. The limitations of survey instruments, especially income-related data need to be taken into account. Another issue worth mentioning is that some patients did not, at first, understand the difference between their willingness to pay and ability to pay. However, this shortcoming does not bias significantly the study findings since willingness to pay and ability to pay was explained to the patients.

5. This study does not purport to evaluate the other alternatives for health care financing and compare them with user fees.

2. LITERATURE REVIEW

2.1. Problems of African health systems and extent of ill health.

The extent of ill health in developing countries, particularly Sub-Saharan Africa is enormous. Infectious and parasitic diseases are still rampant and deficiencies in the standards of health services are extensive (World Bank 1994). For instance, in Sub-Saharan Africa, only one in three has access to safe water. Infant mortality rates remain high. Children continue to suffer from a vicious interaction of malnutrition, diarrhoea and respiratory diseases. These diseases are preventable, and the failure to control them is checking further progress in reducing child morbidity and mortality rates (Hoare and Mills 1986, World Bank 1994).

The World Bank in its policy study of financing services in developing countries (Akin et al. 1987) describes the problems of African health systems as:

* Problems of allocation, characterised by problems of insufficient spending on cost-effective health programs.

* Internal inefficiency of government programs, characterised by the widespread use of higher level facilities by patients who could well be served at the lower level units; and

* Inequitable distribution of benefits from health services, characterised by conditions where 70% or more of the public spending goes to finance urban-based hospitals which provide for the minority

urban population, while simple low-cost interventions for the masses are under-funded.

2.2. Context in which health care reforms are being implemented.

It is worth noting that the context in which health systems operate in most African countries is undergoing dramatic changes. People continue to demand quality health care at a time when the role of the public sector in health care financing and provision is being redefined and countries seek to cope with crippling crises in their economies. Many African countries are undergoing political transition from centralised one-party system towards liberal democracies.

This is further compounded by differences in health status and epidemiological pattern between population groups that are becoming more and more evident. This means that there are population groups suffering from 'disease of affluence' on the one hand, while others from 'diseases of poverty'. These two groups have very different perceived needs and demands for care, causing a double and competing load on health systems with scarce resources.

2.3. Financing reforms and user fees in developing countries.

The aim of reform is to create the necessary conditions for the provision of cost-effective essential health care of acceptable quality, which is accessible to all citizens (Mogedal *et al.* 1995). Reforms may be comprehensive or partial. The aims and options for reform in Sub-Sahara Africa may be similar but the context and approaches taken are different due to diversity of socio-economic and

cultural differences. Yet, what necessitates the government to initiate reforms in the health sector?

Reforms may be initiated due to some perceived dysfunction or serious constraints affecting the health system itself. Contextual factors that generate critical shortages in resource inputs to the sector, changing political commitments and new patterns of demand, represent important triggers of reform. The clarity with which the aims of reform are stated and the time frame set for the reform process varies greatly between countries. Some seek radical and comprehensive change, others selective and incremental interventions. For assessing the outcome of reform, indicators need to be found to determine how well dysfunctions have been resolved and whether there has been improved efficiency, quality, acceptability, relevance and equity (ibid.).

Cost recovery should be viewed as a means to an end rather than an end itself. Whether user charges are successful tools for enhancing health sector objectives depends above all on the organisational and managerial context in which they are applied. In addition to providing additional resources for operations, expansion or quality improvement, it is argued that user fees will increase the efficiency and equity of state health service delivery (Griffin, 1988). This may be achieved by increased funding of cost-effective primary health care. The World Bank on its policy study on health financing (Akin *et al*, 1987) advocated the implementation of user fees on the following grounds:

* Fees dissuade unnecessary use of services and make people more responsible for their own health care.

* The poor and those suffering from infectious diseases (TB, STDs, etc.) can be exempted from paying.

* If fees generated are used to improve level of (health) care, then fees levied may lead to greater consumer satisfaction.

* People tend to value services for which they pay more than when free.

The fact that people do pay for drugs/surgery and health services does not mean that they are able to pay. The market for health care is not the same as that of other goods or services offered in the market, where one may accept or reject the offer. Failure to seek medical care in some instances may lead to death. The argument that the poor demonstrate they can pay when they use traditional healers does not hold water. In this instance payment is usually in kind, and not immediate after the service.

2.3. User fees and equity.

User fees can bring about equity (Griffin, 1988). Griffin argued that the rich tend to use health facilities more often than the poor do, so they could pay more than the poor could and hence reduce inequality. The money collected could be used to provide quality services for the poor who may even get exempted. This is however a polemic argument. Experience has shown that user fees tend to dissuade

the poor from utilising facilities more than the rich. Critics have argued that there is no equity as the poor could not afford to continue using these facilities.

Also it is hard to come up with income-related exemptions criteria especially in a rural setting. For instance, rural people are often subsistence farmers whose income varies seasonally and annually. It is very difficult to determine the poorest as people also hide their true economic status (Gilson *et al*, 1995). The use of household consumption expenditure has been said to be a more reliable indicator than income. Friedman (1957) shows that consumption expenditure is a better measure because it is stable and is less likely to be affected by transitory (current) income. Expenditure has been found to also have practical advantages. Subjects are more often willing to provide information about expenditure than income.

Apart from the administrative difficulties in identifying the poor, the cost of implementing such a strict program to ensure the rich pay could outweigh the revenues collected, especially where user charges are low.

It is both costly and impracticable to attempt to issue annual certificates of inability to pay in rural areas. The incomes of rural people fluctuate greatly seasonally and people are generally not willing to reveal other sources of income. So what could be the alternative for annual certificates of indigence?
Attempts to exempt the poor at the time of treatment are bound to involve rough justice. Some needy patients may not qualify for exemption. This calls for user charges to be modest in order to minimize the time and costs devoted in assessing inability to pay.

Thomas *et al* (1998) suggested a self-selection mechanism, where the poor will identify themselves without having to be selected or

tested by an independent authority. This may be a cheaper and effective mechanism for targeting, where people implicitly reveal information about their wealth when faced with appropriate incentives. Thus, people will identify themselves as rich or poor if it is in their own interest. They argued that if facilities could offer different health-care options based on non-health services, poorer patients will choose the health-care option that is appropriate to their means. The additional revenue from expensive departments in a facility could be used to improve care at less expensive departments (catering for the poor).

Although imposing user fees curbs utilisation of services to some extent, there's no evidence to date that those deterred from using the services didn't really need them (Creese *et al*, 1995). Equity may also be compromised by politics of the allocation process. For instance, powerful demand makers such as urban workers and hospital physicians can create pressure for resources for urban hospitals while rural and preventive services remain under-funded.

Several exemption/targeting procedures have been advocated and relate to geographical (e.g. Slum dwellers), demographic (e.g. Children under five years) and medical conditions of patients presenting themselves at the facility (e.g. Pregnant mothers). The level of household income is often used in targeting. It is important to note that cash income is not the only source of income and determinant of ability to pay for health care services. Other sources available to households include assets, farming, transfer payments etc. and ability to mobilise resources in the face of a sudden contingency (Russel, 1996).

Another important point to note is that certain policy implications (cost recovery) which follow strict economic analysis of targeting may not be politically feasible. For instance Kenya had to shelve cost recovery policy (1990) only nine months after introduction and re-introduce it under another name *cost sharing* (1992). It is argued that those eligible for exemptions may not take advantage of them due to insufficient information about exemption schemes, stigmatisation of receiving exemption and the prohibitive (opportunity) costs associated with accepting the 'benefit' (Thomas *et al*, 1998).

Where the service is offered freely to all, many non-poor people/households use services for which they could pay and may crowd out the poorest from care they could receive. It should also be pointed out that exemption systems are open to abuse as some civil servants, friends and relatives of medical personnel may also receive exemptions. Hence there could exist discretion and misallocation of benefits. Do user fees hurt the poor more than the rich? The answer appears to be yes.

In Kenya, other protection mechanisms also exist. Patients are protected from the cost of catastrophic illness by limiting the number of chargeable inpatient days to 14. Patients pay a flat treatment fee, which means that expensive treatments are more heavily subsidised. The treatment fee is paid only after a patient is actually treated, except for the registration fee which patient has to pay irrespective of whether he/she gets treatment or not. The fee policy also advocates a waiver system for those patients who are not eligible for an automatic exemption and who cannot afford to pay the heavily subsidised fees.

In summary, high fees have the potential to prevent the poor from seeking medical care. The poor are less likely to borrow money from banks for medication since they are not credit-worthy. Although they

can borrow among themselves, cash may not be immediately available. Due to the nature of the market for health care, the poor do sell assets (land) to pay for major illnesses like surgery. The poor are likely to suffer more than the better-off when facilities run out of drugs because they either go without medication or spend scarce time and money travelling to other frequently expensive (private) drug sources.

Finally, protection against user fees will not alone solve the problem of access for the poor. Improving equity and access must also include removing or compensating for non-monetary barriers like distance, quality perception, drug availability, education, cultural barriers, etc. that pose an equal or greater obstacle than fees for service. More field experience and means testing is needed to find cost-effective approaches to protecting the poor under cost recovery.

2.5. Net revenue generation.

The knowledge of net revenue generated from the fee policy is important to policy makers. An analysis of net revenue generated in some Eritrea health stations was found to be negative (Eyob A., 1998). In a similar analysis of Groote Schuur hospital and its satellite facilities in Cape Town, South Africa, nearly 55% of the fee revenue of state patients was spent on collecting these fees in the case of inpatients, while collection costs exceeded fee revenue by 150% in the case of out-patients (Jurgen *et al*, 1996).

The adequacy of fee revenue is critical to quality improvement in any particular context. In particular, cost recovery reforms are most likely to work when fee revenues are ploughed back into the delivery

system to improve quality. The perceived quality of care and fee levels both act as critical determinants of facility utilisation.
Thus an assessment of fee impact is likely to be misleading if quality of care is not taken into account. Experience has shown that the poor respond more strongly to quality than the better off. In essence, poor quality of service deters the poor from seeking care more than fees and distance (Gilson *et al*, 1995).

2.6. Willingness and ability to pay.

The willingness and ability to pay for public health care are critical determinants of sustainability of health care. Affordability of care has become a critical policy issue in developing countries as households make out-of-pocket contributions to their health care as well as other expenditures like food, school fees etc. Households expenditure on health could force them to cut down on essential or basic necessities such as food, education, etc. (Russel, 1996).

Is there difference in the willingness to pay for health care before treatment and after treatment is effected? If the policy is to treat first and seek payment later, willingness to pay could be much less after treatment than before. In the rural areas, willingness to pay after treatment is exaggerated by the fact that people are accustomed to paying less for their health care.

2.7. Pricing policy for user fees.

What is the role of price in the demand for health care? In the economic theory of demand and supply, price is a key determinant of consumption behaviour, assuming other factors constant. Given the key

role price plays in influencing demand for health care, significant price increases may dissuade patients from seeking care. This is more so because the demand for health care is inelastic. In the last decade, increasing attention has been directed to the role of price in the demand for and utilisation of health services. Cost recovery, achieved through the pricing of services and the charging of fees to users, has played a minor (though increasingly) role in generating resources for facilities and services. Slow economic growth/decline in the 1980s forced many governments to reduce budgets for health and other social services. The charging of fees to users of government health services is generally considered a first step to recover costs from and generate revenues for health services (World Bank, 1987).

But, how much cost recovery is possible? Assessment of the limits of cost recovery of user fee policy is dependent on geographical, socio-economic and service delivery settings. Many African countries recover only a small percentage of their recurrent budgets from user fees (McIntyre 1997). Low revenue generation may be attributed to ambiguous policies, poor management and lack of central-level direction (World Bank, 1987). Ideally, economic theory recommends that price of a good or service should be set where marginal revenue equals marginal cost. However this is not advisable for public health facilities to charge such a competitive price since the goal is not profit maximization. This study suggests that user charges should reflect an estimate of average costs of relatively measurable inputs such as drugs, supplies, reagents etc. Costing is a tool/technique for measuring the amount of the resources used to deliver services. In the Kenyan context, the literature does not explain which (costing) criteria the MOH use currently to set user charges.

2.8. Implementation of user fees in Kenya.

From independence up to December 1989, the Government of Kenya provided health services in public clinics and hospitals free of charge in accordance with its social policy (Republic of Kenya, 1989a). In the late 1980s the government began to review this practice as its fiscal deficit worsened and its ability to meet recurrent health expenditure of the public health sector declined (Mwabu et al, 1997). The research available at that time indicated that moderate user charges in public facilities would alleviate the budgetary constraints of the Ministry of Health (MOH), and at the same time rationalise the use of medical services without significantly reducing clinic attendance (REACH, 1988). As the government was seeking other sources of financing health, it was facing pressure from external donors (World Bank, 1987) to introduce market-oriented reforms in the health sector as a condition for development assistance.

With some hesitation, the government finally introduced user charges in all public hospitals and health centres in December 1989. The highest fees were to be charged in the referral Kenyatta National Hospital (KNH), lower at District hospitals and lowest in the health centres (Republic of Kenya, 1989b). Preventive services and treatment for catastrophic illnesses were exempted from fees. Poor patients were supposed to be exempted on presentation of evidence of inability to pay. The facilities were required to retain 75% of the fee revenue they generated and remit the remainder to their respective District Treasury for funding Primary health care activities (Dahlgren, 1990). The facilities however could not spend the revenue they generated without authority from Treasury.

The initial implementation was characterised by many problems. A good number of patients who could not afford to pay were denied care. The government finally suspended outpatient fees with immediate effect on September 1990 (nine months after implementation) for a number of reasons:

- The fees were denying a large number of people access to medical care (Dahlgren, 1990). Many people found it hard to pay for services they had been getting free. In addition, it was hard to determine who was poor for exemption.
- The anticipated improvements of perceived quality of care weren't forthcoming. Revenues generated were too small to improve quality of service significantly.
- Shortages of essential drugs and other medical supplies persisted. Revenues generated were not enough to procure essential drugs and there were delays in releasing money from the Treasury.
- There was a general lack of consensus among the medical staff about the acceptability of the user fees. Members of staff were not adequately consulted over the fee policy before it was implemented.

Following the initial introduction of user charges, utilisation initially declined, patients were not willing to pay for services they had been getting free, or for which they weren't able to pay. Outpatient utilisation declined by 53% in all facilities on average (Mwabu *et al*, 1997). Some poor patients found it hard to seek health care perhaps due to stigmatisation or failure of exemption criteria. In

most cases user fees have had negative consequences for equity because income-related exemption measures have proved difficult to implement (Creese and Kutzin 1995, Gilson *et al*, 1995). The revenue from user fees in Kenya accounted for approximately 3.5% of the MOH recurrent budget in 1991.

However the inpatient charges continued. In 1993, the user charges generated Ksh. 7 million (*Quick et al*, 1993) which accounted for no more than 3% of the MOH Recurrent Budget. Facilities were required to bank cash collected with their respective District Treasury. This meant that cash was not immediately available to facilities. In fact there were delays in replenishing supplies due to the failure of the Treasury to release funds. Thus, some facilities found it hard to utilise the revenue they had collected.

In April 1992, the Government reintroduced the fees under the name "cost sharing". This term was more acceptable to patients than the former cost recovery. The cost sharing was to be implemented in phases, starting with KNH referral hospital, followed by provincial hospitals (July 1992) and district hospitals (Jan. 1993) (Collins *et al*, 1996). This implementation strategy was meant to discourage utilisation of the more expensive hospital-based care and encourage the use of primary health care at lower level facilities. Phased implementation was manageable and allowed problems encountered to be rectified unlike in the former case where fees were introduced in all public facilities at once, except dispensaries. Upon fee re-introduction, the dispensaries continued to offer free primary care and facilities continued to retain 75% of fees collected. Low charges at first contact facilities, higher at district hospitals and highest at tertiary levels send signals to potential consumers that can affect utilisation (Bennet *et al*, 1994). It is important for the management to

ensure that poor patients exempted at lower level facilities are also exempted at higher level facilities.

Primary health care (PHC) has been shown to be a cost-effective way of disseminating care to the rural population. Many of the illnesses in developing countries can be prevented by primary health care initiatives. Governments, should therefore, as a matter of urgency deal with the constraints to more effective use of primary health care. In particular, additional resources both human and financial need to be channelled to this area. Currently more resources go towards financing curative care. This may indicate a need for policy makers to revise resource allocation i.e. between curative and primary health care.

Facility-based District Health Management Boards (DHMBs) were established by Government gazette notice in 1992. These boards were to help in hospital administration in particular planning, co-ordination, monitoring and recommending policy actions. Such board members are usually picked from the local successful businessmen. They purportedly represent public interests with regard to decisions taken by hospital administrators, but they often do not.

The new fees differed from the previous ones in that:

- patients were required to pay only after treatment,
- authorisation to spend user fees were to be given by the newly created District Health Management Boards (DHMBs) and
- Population eligible for exemption were specified i.e. the unemployed, civil servants and military personnel.

Note that, though there were national guidelines to charging fees, hospitals started to charge different fees, though the fee variations were not significant.

2.9. Summary of relevant points for this study.

From the literature search above, the following issues are important in this study. Fees implementation should occur in phases from top to bottom, starting from tertiary hospitals, allowing fees and systems to be tested, and training and supervision skills to be developed and expanded, before widespread implementation takes place. It should be emphasised that full and proper implementation of user fee policy will take several years. Thus, constant monitoring and supervision is a must for policy to succeed.

The MOH should be aware that skills and motivation vary considerably among staff, and bringing about system and attitude changes takes time. It is important to note that some facilities and individuals will proceed more slowly than others, therefore, reinforcement training and constant supervision is a must. These measures will require additional resources that may be financed by additional budget allocations and efficiency savings.

Accessibility of health care is important in fixing fee levels. Assessing the willingness to pay and ability to pay is important before fixing fee levels. Poor people are accustomed to paying less than the market rate for their health care in developing countries. The MOH must ensure that those unable to pay or those who suffer a lot by paying are

exempted, as the literature on exemption says. This will go a long way in enhancing equity as high fees may discourage facility utilisation by the poor. Other variables that may deter utilisation such as distance from a facility, drug availability, level of education etc. will also have to be addressed. Effective targeting procedures need to be developed, which may involve a combination of variables such as household income, property owned, farming income etc. The MOH should also evaluate the capacity to utilise exemptions by the poor as other factors (i.e. stigmatisation) may inhibit the poor from making use of exemptions. Illnesses with positive externalities should continue to be offered free of charge.

Cost recovery should be viewed as a means to an end rather than an end itself. In particular, revenue generated should be expended in priority areas that will offer greater satisfaction to patients. Availability of drugs ranks the highest with regard to quality perception. Poor patients are likely to suffer more when hospitals run out of drugs. User fees alone cannot be relied upon entirely to offer quality health care of acceptable quality. The amount of net revenue to be generated and its capacity to increase in supporting health service provision is critical. Other sources of financing health care should be explored, to supplement user fees, given their low revenue generating ability.

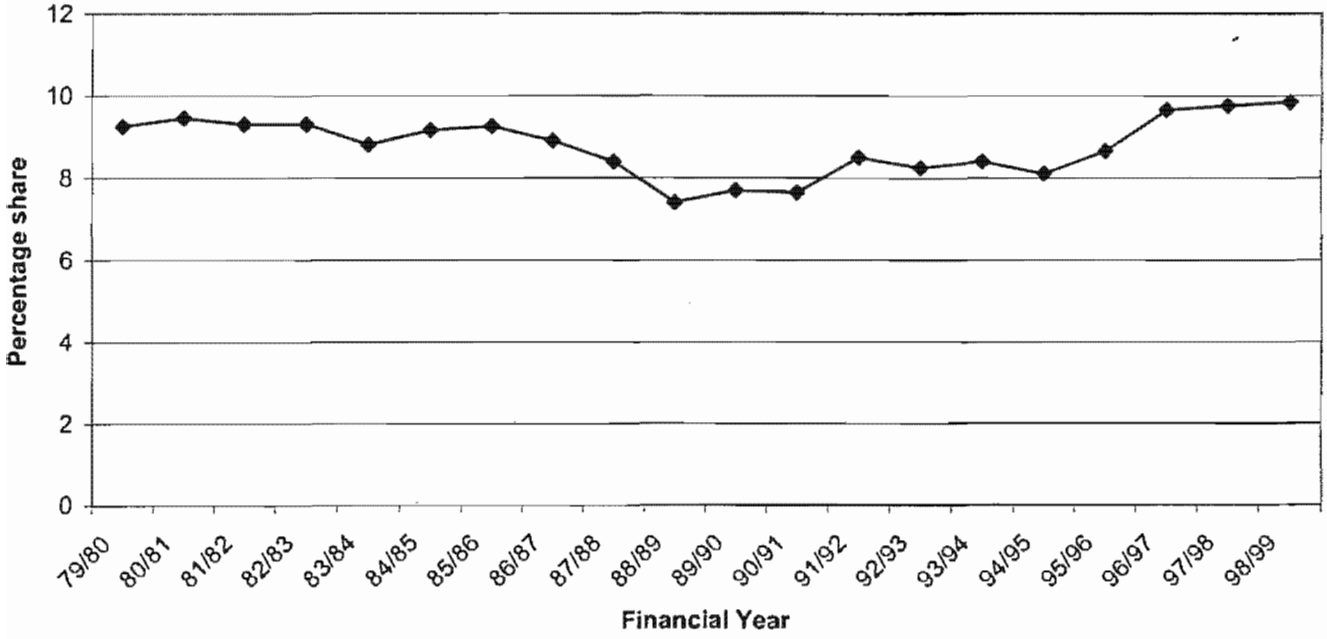
3. COUNTRY HEALTH FINANCING PROFILE.

3.1. Review of health care provision and financing.

As noted earlier, the Kenyan economy has not been doing very well. The country continues to depend on agriculture as her mainstay. The country is therefore vulnerable to severe fluctuations in export earnings. Nonetheless, the government has shown commitment to increase resources in the health sector. The share of the MOH Recurrent Vote in the government Recurrent Budget stood at 9.6% in 1996/97, and currently at 9.77% in the 1998/99 Financial Year. The per capita MOH spending stands at US$ 6.2, out of a national total per capita health spending of US$ 14.77 (other sources contribute US$ 8.57). This figure tallies with Kenya's expenditure ranking according to the World Bank (1994). Kenya is ranked among medium health expenditure sub Sahara countries. Such countries include; Burundi, Cameroon, Gambia, Ghana, Kenya, Liberia, Malawi, Niger, Rwanda, Senegal and Zambia, which spend around US$ 16 per capita on health care (World Bank, 1994). With proper reforms, this level of spending is more than enough for a basic district-based health care system. Such a health care system has been estimated to cost only US$ 13.22 per capita (*ibid.*).

The MOH's share in the National Ministerial Recurrent Budget has been showing an upward trend from 1988/89 onwards (see figure below), though over twenty years has been stagnant.

The MOH's share in the Government's Recurrent Expenditure from 1979/80 to 1998/99.



An analysis of both the government and MOH Recurrent Expenditure shows that, the MOH's share fell from about 9.3% between 1979/80, to around 8% between 1986/87 to 1994/95. This figure rises to about 9.6% in 1996/97 and further to 9.8% in 1998/99. This upward trend is expected to continue. This is a strong indicator of the Government's commitment to increase the level of resources in the health sector.

A review of MOH expenditure shows that rural health services and PHC has been somehow increasing. This has however been slow and appears to have reached its limit, and has mainly been derived from the Development Vote. The latter is over 85% reliant on foreign donors, a situation that is unsustainable. Curative care has been most adversely affected by the government's decline in real expenditure. This has resulted in the widening of the curative financial gap, especially for district hospitals, which in 1992/93 required about 80% in additional

funds to operate efficiently (Kamigwi J., 1996). Revenue from user fee policy plays a vital role in supplementing the Recurrent and Development Budgets. Its major impact has been to supplement recurrent non-wage resources. In 1998/99, cost-sharing resources amounted to 25% of the Recurrent Vote non-wage resources (ibid.). At the facility level, cost-sharing revenue has perhaps been preventing the perceived quality of care from deteriorating rather than helping to increase the quality of care (see section 6).

3.2. Primary Health Care (PHC) initiatives

As noted earlier, the government has adopted PHC initiatives since 1978 as a cost-effective way of offering health care to her people. This is because many of the illnesses and deaths in Kenya can be averted through effective provision of PHC. Clear understanding of weaknesses of PHC by the policy makers will help them in instituting corrective measures. Such weaknesses are highlighted in this subsection and include:

a).Concentration of budgetary resources on hospital based curative care.

b). Poor co-ordination between private / public facilities in effecting PHC. Private sector does not participate in PHC activities.

c). Weak delivery system for primary health care due to inadequate financial resources, program supervision and few trained health/social workers.

d). Poor infrastructures (i.e. road network), lack of clean water, high population growth rate, illiteracy, etc. Sheer poverty compounds the situation.

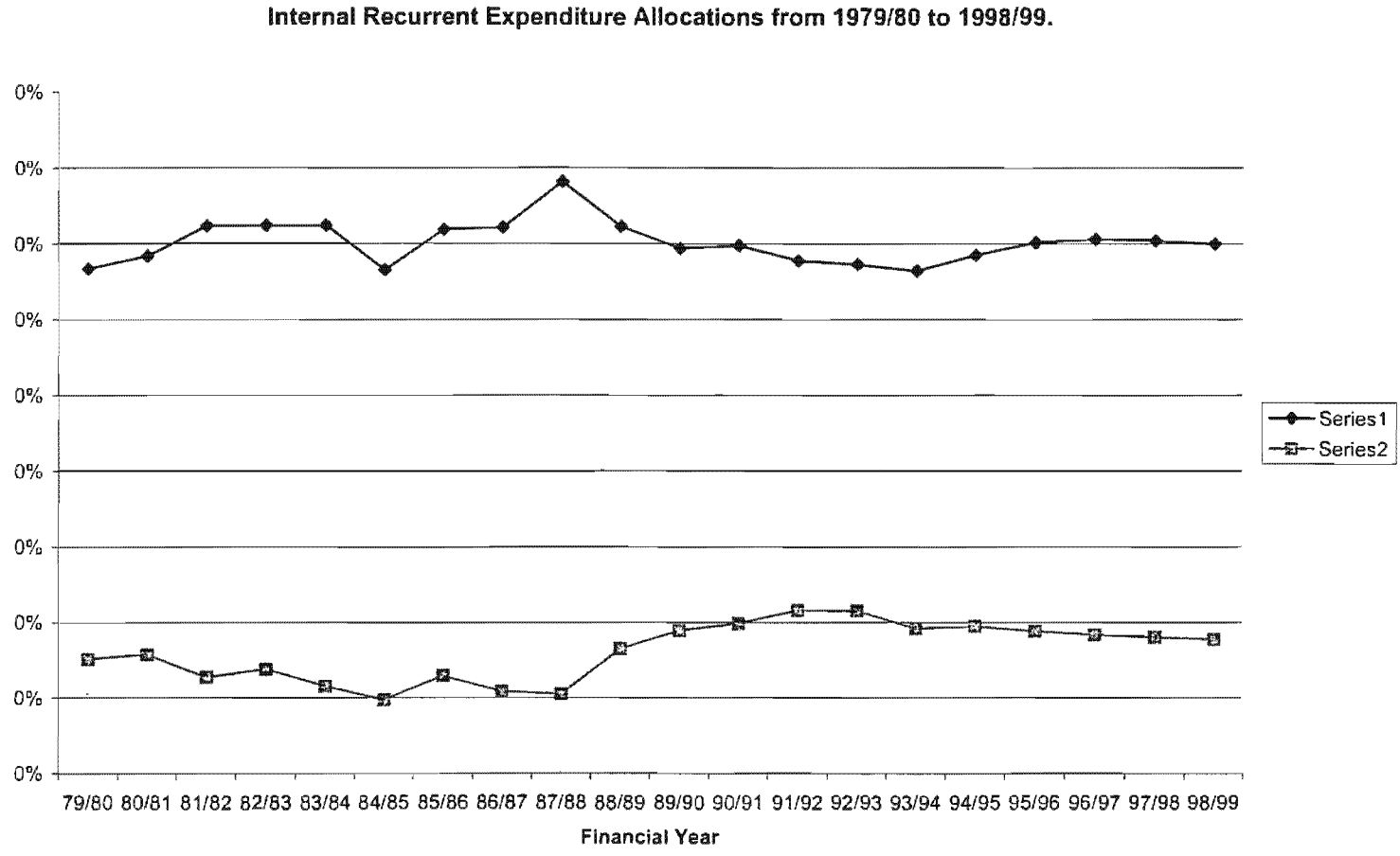
e). Only 25% of revenue from cost sharing goes towards PHC. The poorer districts get little funds for PHC compared to better off regions.

f). Inefficient use of existing health facilities. E.g. patients use hospitals for primary care, bypassing local health centres and dispensaries where such services are available.

The above shortcomings need to be addressed without further delay. MOH must work closely with other ministries i.e. ministries of transport and water resources that will improve access and water provision to rural areas. Provision of primary health care urgently calls for the intensification of the training of middle and low-level health workers, a move that is cost-effective. These health workers are effective in disseminating and educating the masses on important issues such as immunisation, family planning, sanitation, etc. Policy makers must also design ways of encouraging firms in the private sector offering medical services to participate in PHC initiatives, not just curative care. Patients should also be encouraged to use PHC facilities first.

3.3. Ability of government to offer quality care.

The capacity of the government to offer quality health care to her people may be assessed by recurrent expenditure allocations (see figure below).



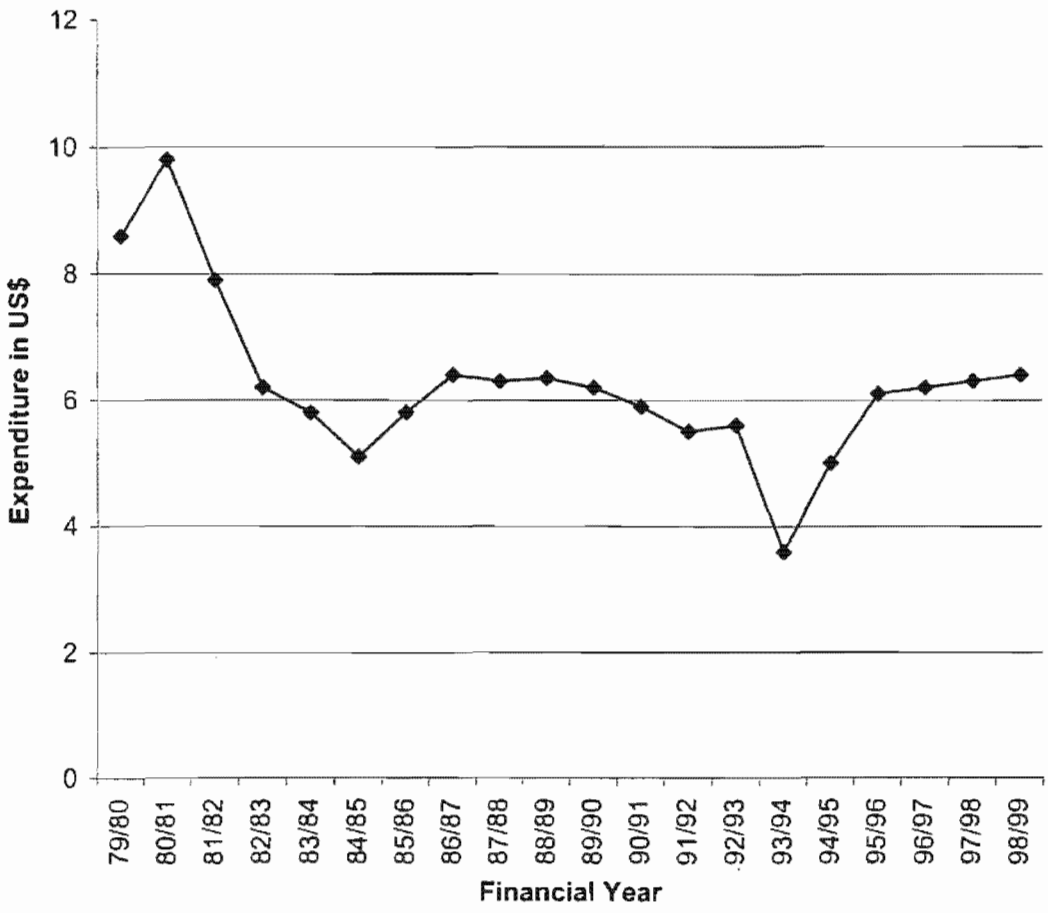
Series 1 = hospital based curative care

Series 2 = PHC

From the graph above, we can see that more resources continue to be channelled to hospital curative care rather than PHC. This may indicate a need to revise MOH resource allocations. More financial resources are needed to boost PHC operations. This internal recurrent expenditure is important because it does not include any donor finance. It is crucial in reflecting the commitment and ability of the government to implement policies. The donors do not like to finance recurrent expenditures; they prefer the development expenditures. For instance the 1995/96 Printed Budget (Republic of Kenya 1995a) donor contributions amounted to 88.9% of the Development budget leaving only 11.1% to be financed by the government. In addition, donor loans that later have to be repaid accounted for 23.3% of the budget.

The ability of the government to offer health care to her people may also be assessed by the expenditure per capita. In the Kenyan context, The MOH expenditure per capita is low, and has fluctuated within a narrow band of US$ 6 since 1982/83 (See graph below).

Real MOH Expenditure Per Capita from 1979/80 to 1998/99 in US Dollars (US$).

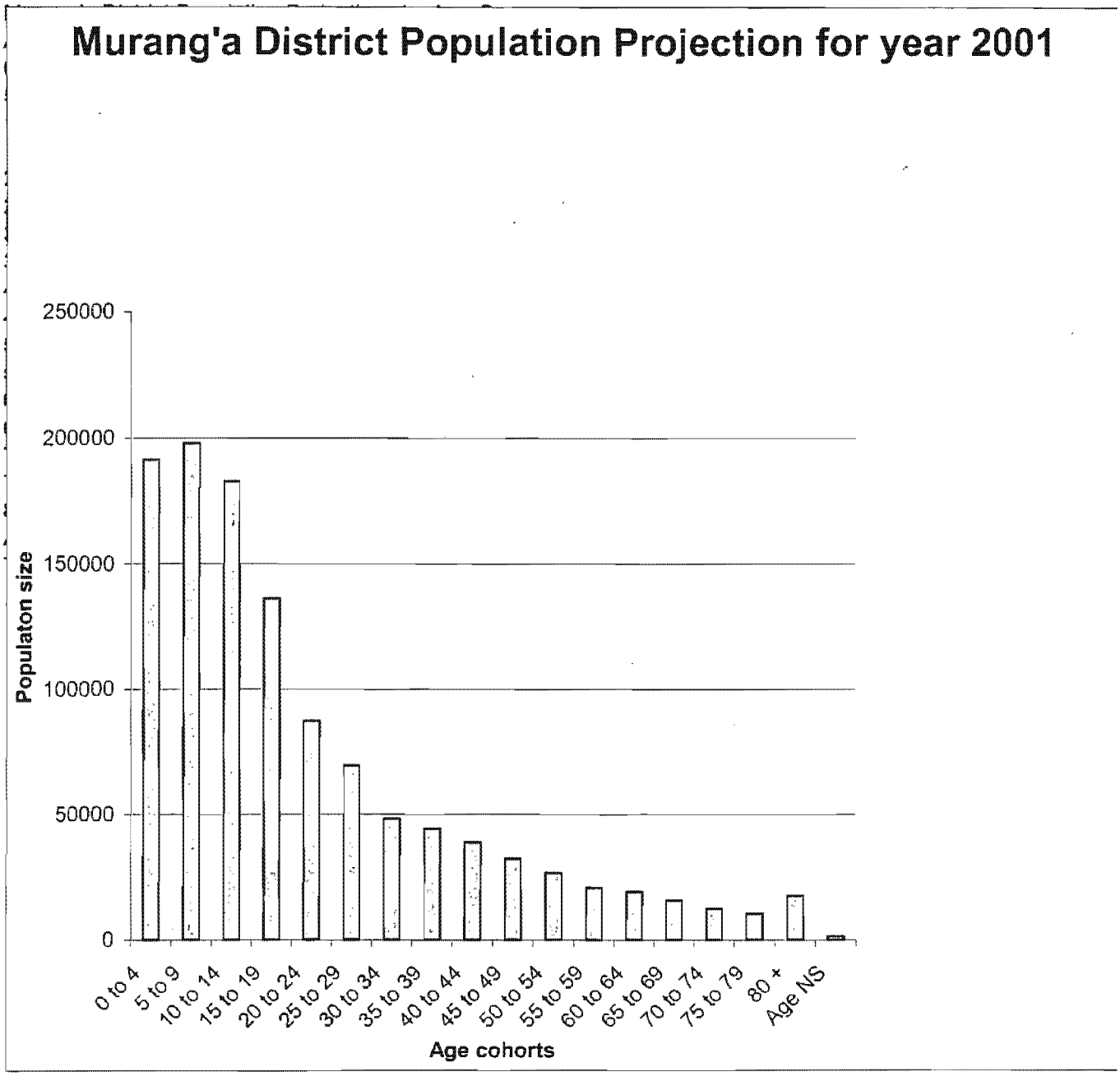


The MOH real per capita expenditure was lowest during 1993/94. Kenya experienced a severe drought this year. The relative stability of the real MOH per capita health expenditure is a strong indicator of the government's commitment and consistency in supporting health care. However, the government needs to increase budget allocation in real terms to health care since this is also an investment in human capital. User fees are a source of funds for additional recurrent expenditures at the facility level.

4. PROFILE OF THE STUDY AREA

This study was conducted in the three districts of Central Province namely Murang'a, Kiambu and Nyeri. These districts have similar characteristics with respect to temperatures, rainfall and topography. Temperature is influenced by altitude. Average annual temperature ranges from 20°C and 30°C. In general, these districts receive high and reliable rainfall ranging from 900mm to 1600mm per annum. Many people engage on small scale farming i.e. growing cash and food crops as well as rearing cattle and poultry (refer to Murang'a, Kiambu and Nyeri District Development Plans 1997-2001).

These districts have a large proportion of youthful population. This age group represents more than 50% of the total population in each of these districts. The population projection of Murang'a district up to the year 2000 is shown below.



NS = Age not stated
Source: District Planning Unit, Murang'a, 1996.

4.1. Summary of the study area (Central Province).

4.2. Geographical analysis.

The geographical features of the study area have some bearings on the epidemiological profile. For instance the warm, humid and wet climate promotes the breeding of mosquitoes and this indicates that malaria is rampant especially in the lowlands. In fact malaria ranks the highest in the Central province morbidity list. This calls for an increase in preventive measures (which are cost effective) and may indicate a need for a revision of resource allocation. Given scarcity of health care resources, the MOH can no longer afford to sacrifice allocative efficiency.

Agriculture is the major economic activity meaning that most people's incomes vary both seasonally and annually (there are two seasons in a year). Incomes are higher during the harvesting season and lower during the planting season. This influences the people's ability to pay for their health care. The time cost incurred in seeking health care during the planting and harvesting period is much higher than other times because people are actively involved in farming.

4.3. The health profile

The causes of morbidity and mortality in the study area are those typical of less developed countries, and are responsive to preventive/primary care interventions. Such diseases include malaria, diarrhoea, STD/AIDS, etc. This calls for optimal allocation of resources, shifting resources away from tertiary level facilities and programs to more cost-effective interventions, which also have positive externalities. If part of the user fee revenue generated could be effectively channelled to finance these cost-effective programs, equity

might be enhanced. It is encouraging to note that the Government has adopted the promotive and primary health care (PHC) since 1978 as the cost effective and viable approach in providing health care to her people.

5. METHODOLOGY.

5.1. Data sources

The following summary table of objectives, data requirements and data sources will help us in working through the objectives.

Table 4.2.

Summary table of objectives, data requirements and data sources.

Objective	Data required	Data sources
Exemption policy and equity	- Utilisation data - Views of patients and medical staff	- facility records - interviewing patients and medical staff
Financial sustainability	- net revenue generated - willingness to pay & ability to pay	- revenue data from MOH headquarter - cost data from facilities - interviewing patients
Perceived quality of care	- Patient perceptions of drug availability, staff competence and attitudes, facility appearance, etc.	- Interviewing patients and medical staff
Acceptability of	- Revenue generated	- MOH headquarters

staffs were issued with questionnaires to fill in. The questionnaires were structured such that the objective(s) i.e. financial sustainability, perceived quality of care, acceptability of scheme, exemptions and equity (as outlined in table 4.1.) could be assessed.. Before the actual interview took place, it was found useful to circulate the structured interview schedule for both inpatients and outpatients among colleagues to assess clarity and to identify issues that might have been overlooked.

5.4. Sampling.

For the purposes of analysing the user fee policy, the convenient sampling technique was employed. This involved choosing facilities that can be accessed with ease due to financial and time constraints. The Central province was purposefully chosen for its convenience and its high potential for cost recovery. The term cost recovery here denotes the charging of user fees from patients by providers, in order to try and recover partly or wholly the cost incurred in disseminating care (See appendix for definition of 'cost recovery'). Several factors make people generally better off in Central province compared to other areas. This province borders the capital city of Nairobi and people engage in trading, dairy and poultry farming, offering rental houses for commuters in Nairobi, etc.

This study was intended to focus on public hospitals only. In this regard, four facilities were chosen in Central province. Nyeri provincial hospital (the only provincial hospital), and out of the six district hospitals, Murang'a, Kiambu and Tigoni sub district hospital were chosen at random.

Data collection for inpatient, outpatient and staff took five days in each of these facilities. I had five research assistants. Prior to data collection, I had trained them on data collection techniques and made them understand each and every question to be posed. Permission to visit the facilities was granted by the Director of Medical Services, Nairobi.

5.5. Interview dates.

Hospital	Interview dates
Murang'a	04/01/99 - 08/01/99
Nyeri	11/01/99 - 15/01/99
Kiambu	18/01/99 - 22/01/99
Tigoni	25/01/99 - 29/01/99

5.6. Inpatient responses.

For inpatient responses, all the facility wards were visited. It was not possible to employ the systematic sampling technique as intended since the majority of the patients were too ill to respond to questions posed and some beds were unoccupied. In some instances, the nurse in charge (of a ward) was requested to pinpoint candidates for interview since there was no need to wake patients up who could not respond. Before the actual interview started, we requested the nurse in charge

to inform the patients that they would not be victimised for their responses. This acted as a great relief to patients since some of them were afraid of victimisation should they discredit the facility. It is important to note that questions were posed in local dialect or Swahili as many people don't speak English.

The structured interview schedule consisted of four sections. The first section was a note to the interviewee explaining the purpose of the study, highlighting the fact that the views of the consumers are of paramount importance in policy design and revision, and assuring respondents that confidentiality was guaranteed. The second part consisted of questions related to socio-economic and demographic characteristics of the patient. Part three consisted of questions relating to illness and health service utilisation. Part four consisted of willingness to pay fees, ability to pay and exemptions.

5.7. Outpatient responses.

For outpatient responses, the structured interview schedule was similar to that of inpatients, except for some changes in the questions asked to reflect the fact that the patients had gone through the system - fee payment (or waiver/exemption) process. This was a kind of 'exit' interview in that whoever was found leaving the facility was approached and asked to participate in the study as a respondent. This interview was therefore not random (weaknesses of non-random sampling applies here). As stated in the section on limitations of the study, because of suspicions that people had, a few didn't volunteer. This may have introduced some biases.

5.8. Staff responses.

For the staff responses, staff questionnaires were distributed to all the departments, through the departmental heads in proportion to their numbers. They were distributed on Monday and collected on Wednesday, Thursday and Friday. The structured questionnaire schedule consisted of four sections. The first section was a note to the respondent explaining the purpose of the study, highlighting the fact that the views of the providers are of paramount importance in policy design and revision, and assuring them that confidentiality was guaranteed. Providers are critical actors in the fee policy reform and, the policy will never succeed if they do not support it. The second part asked the professional group of the respondent e.g. doctor, nurse, administrator, etc. Part three consisted of questions relating to user fee policy, health care utilisation, and staff experiences and sought their recommendations for the MOH. Out of 125 questionnaires distributed to the staff, only five defaulted in filling them.

5.9. Costing of hospital services.

The costs incurred by the facilities in providing care (see section 7) were collected from the respective hospital accounts department, supplies department and hospital secretary office. In the case of overheads such as water, electricity and phone bills, monthly average costs were taken, as these costs tend to fluctuate. For the fee office(s) rentals equivalent, the cost of renting an equivalent office(s) in the vicinity of the hospital was taken. The average salaries (gross) of hospital staff and clerks dealing with cost sharing

money were taken from the MOH headquarters (salaries department). It was found necessary to do so rather than asking them to disclose their salaries as people generally do not disclose their true incomes.

Data was analysed using STATA software.

6. SURVEY RESULTS & DISCUSSION.

The table below shows some of the fees currently being charged by hospitals under study.

Hospital charges (1US$ = Ksh.72).

Service	Charges (Ksh.)*			
	Nyeri hosp.	Murang'a hos	Kiambu hosp.	Tigoni hosp.
Out-patient registration & consultation	30	20	20	20
Maternity (normal delivery)	650	400	500	300
In-patient charge per day	100	100	50	50
Pharmacy (drugs per item)	20	20	20	20
Lab (ordinary test)	60	40	40	40
X-ray test	200	200	250	-
Operation (minor theatre)	200	100	100	-
Mortuary charge (per day)	200	200	200	200

* 1US$ = Ksh. 72.

6.1. Acceptability of the fee policy.

Acceptability of the user fee policy to providers and consumers of public health care is important for the policy to be successful. Sometimes you may find that policy makers impose a policy on providers without necessarily explaining the implied objectives of such policies. With this in mind, the hospital staff (respondents) were asked if they were aware of the user fee policy objectives. Their responses are shown in table 1.

Table 1.

Awareness of user fee policy objectives.

aware	Freq.	Percent	Cum.
yes	113	94.17	94.17
no	7	5.83	100.00
Total	120	100.00	

This shows that about 94% of staff of MOH think they know the objectives of the user fee policy as stated above. In order to assess their understanding of the objectives, they were further asked to state the most important objective. The response was as follows:

Table 2.

The most important objective of user fee policy.

objective	Freq.	Percent	Cum.
generate revenue	13	10.83	10.83
improve quality of services	100	83.33	94.17
improve accessibility (under-served areas)	7	5.83	100.00
Total	120	100.00	

About 83% said that the most important objective is to improve the quality of services. This is quite true. We can conclude that the MOH has made its staff aware of the user fee policy objective(s) and this is commendable. The most important explicit objective of the policy is not to raise revenue but to improve quality of services. None of the staff said that he/she does not know what the fee policy is aiming to achieve. This is encouraging.

In order to assess provider support of the fee policy, the staff who were in service prior to its implementation, were asked to state whether patients should pay for drugs, hospitalisation and diagnostic tests. This was purposefully done because such staff could tell the difference between quality of service before and after user fee policy implementation. The majority of the staff felt that patients should pay for drugs, hospitalisation and diagnostic tests. We can conclude that majority of the staff support the user fee policy. However, the MOH should hold seminars (say on annual basis) to assess staffs' continued support of the user fee policy. Currently it does not hold such seminars as the staff responses indicated. See table below.

Table 3.

Do members of staff attend seminars/workshops on cost sharing?

seminars attendance	Freq.	Percent	Cum.
Yes	12	10.00	10.00
No	108	90.00	100.00
Total	120	100.00	

For the acceptability of user fee policy by the patients, see the section on willingness to pay for the services offered.

6.2. Perceived quality of care.

The way providers and consumers view the perceived quality of public health care is crucial to the success of this policy. One of the aims of the fee policy is to raise the quality of care (especially in the eyes of the patient). This is one reason why user fees are charged in order to try and recoup some of the costs incurred in providing care. It is argued that if revenues collected could be ploughed back, this could raise the quality of services offered.

The staff who were in service before user fee policy implementation, were asked to state whether they're now facing more, less or the same problems in their duties. On average they responded that they continue to face the same problems (see table 4 ahead). It can be deduced that the user fee revenue has done little to improve the quality of care. At best, it can be inferred that the revenue generated has helped to prevent deterioration of the quality of care.

Similarly, the MOH staffs were asked whether they have witnessed the following conditions after implementation of fees (with respect to some services): The table below depicts their responses.

Table 4.

On average, has staff witnessed the following conditions?

Phenomena	YES (%)	NO (%)	N/A (%)
Decreased waiting time	36.1	62.8	1.2
Rational use of resources	30.2	60.5	9.3
Increased availability of essential drugs	26.7	66.3	7.0
Improved nursing care for patients	30.2	64.0	5.8
Increased patients coming with referral slip	29.1	62.8	8.1
Increased essential diagnostic tests	26.7	57.0	16.3

The above table shows that most staff agree that the above services have not improved as a result of fee implementation. This suggests that fee revenue has not improved the perceived quality of care. The overall quality of service was voted as fair (62.5%).

The respondents were asked to state other specific issues they would like the MOH to consider and the response is shown in table 5.

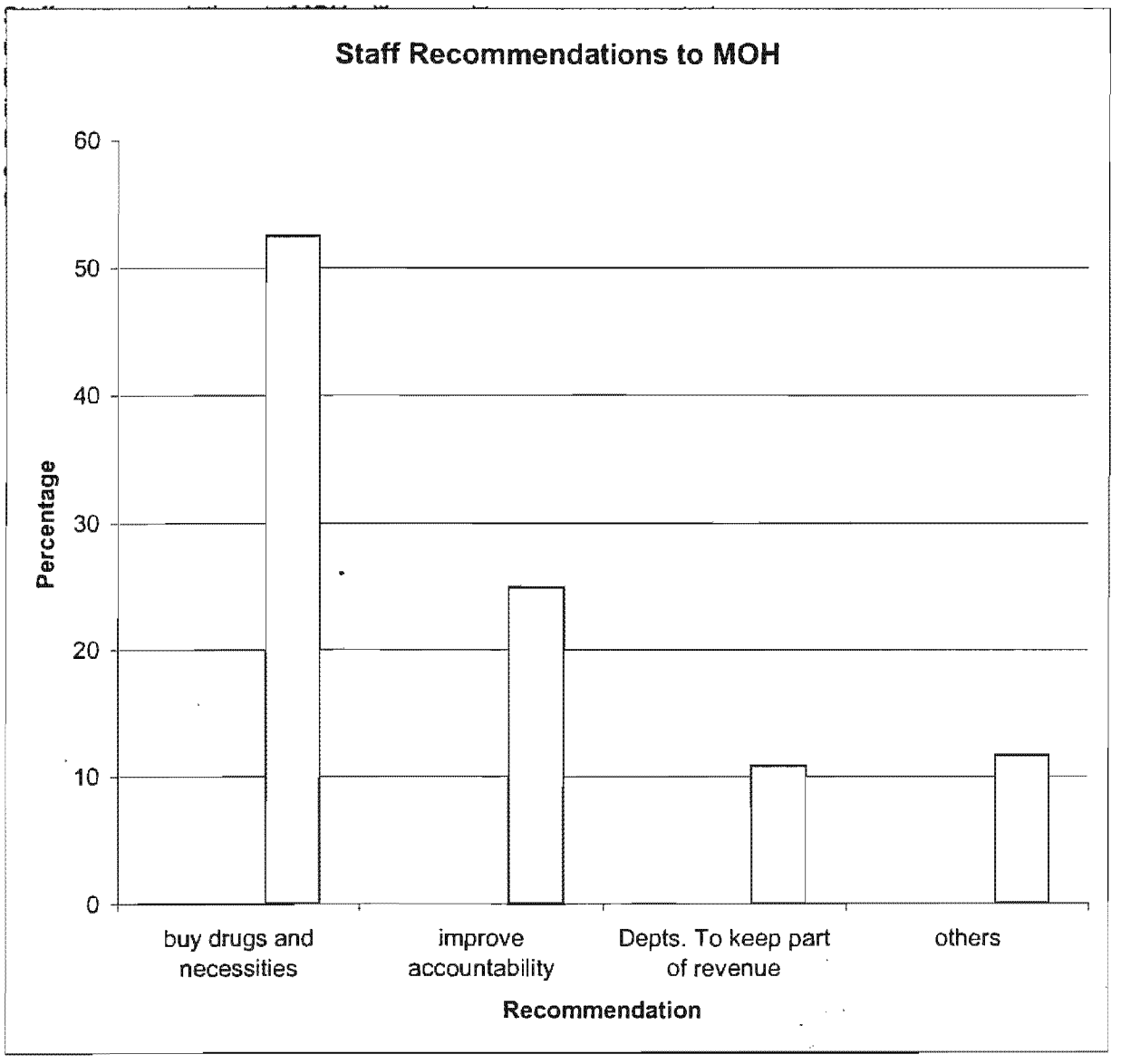
Table 5.

Other issues members of staff would like to see improved.

Phenomena	percentage	Frequency
Discretion in fee charging	3.3	4
Giving waivers	7.5	9
Fee collection/usage efficiencies	33.3	40
Addition of staff	4.2	5
Improved hotel facilities	20.8	25
Others	30.8	37
Total	100	120

Majority of respondents (33%) said they would like to see fee collection and usage improved. This suggests that accountability and transparency in fee revenue is a must. The MOH has laid down measures to ensure efficiency is observed, but there is still room for improvement. Many of the staff recommended that revenue generated could be used to procure essential drugs. See the tabulation below:

Table 6. Staff recommendations to MOH.



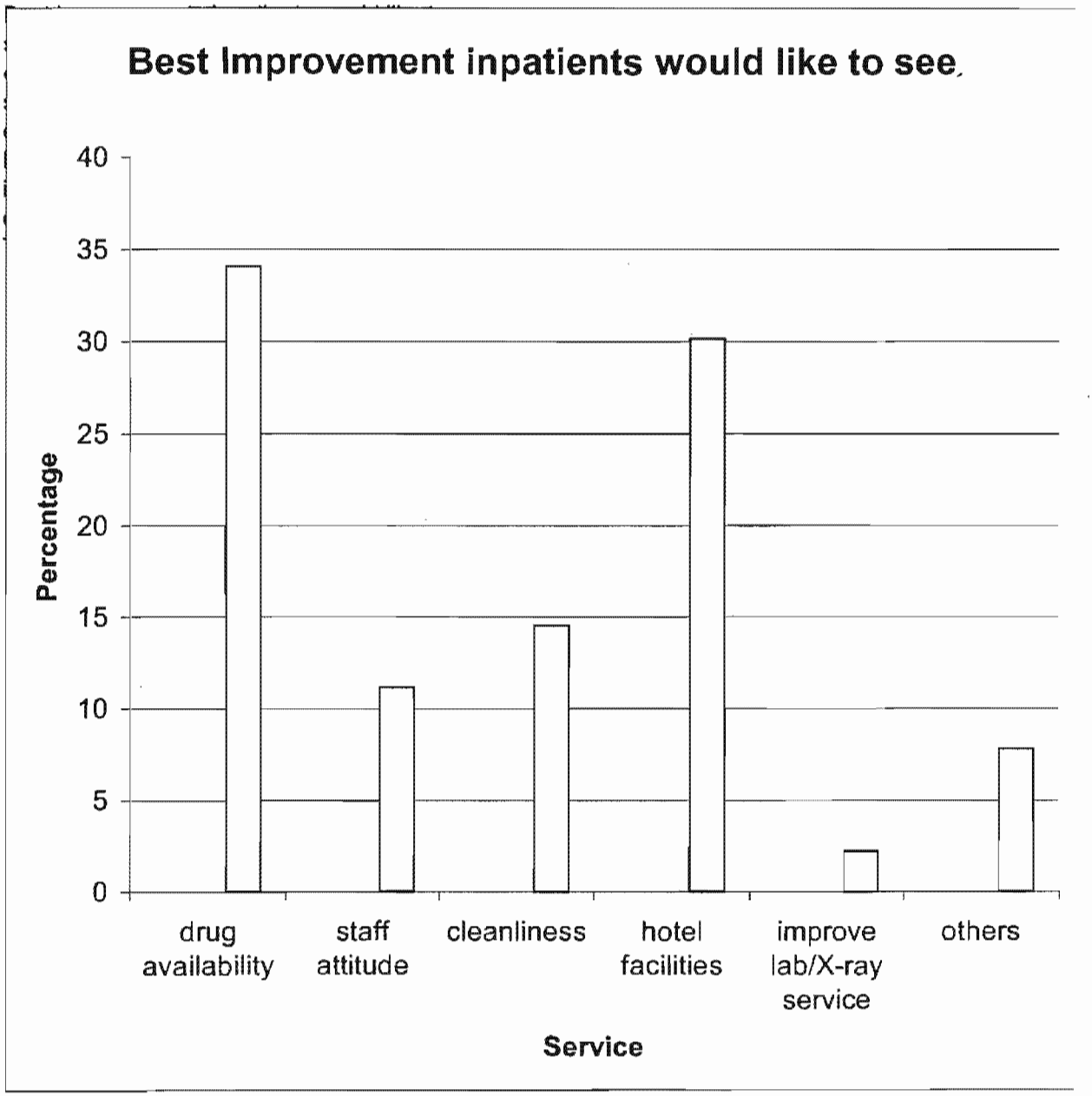
Over 52% said that the fee revenue generated should be used to buy drugs and other necessities. This response further cements the importance of drug availability in public hospitals. Availability of drugs is critical indeed.

6.3. Inpatient and outpatient views on improvements.

Inpatients were asked the most important thing (service) they would like to see improved. Drug availability ranked the highest, see graph below.

Table 7.

Best improvements inpatients would like to see.

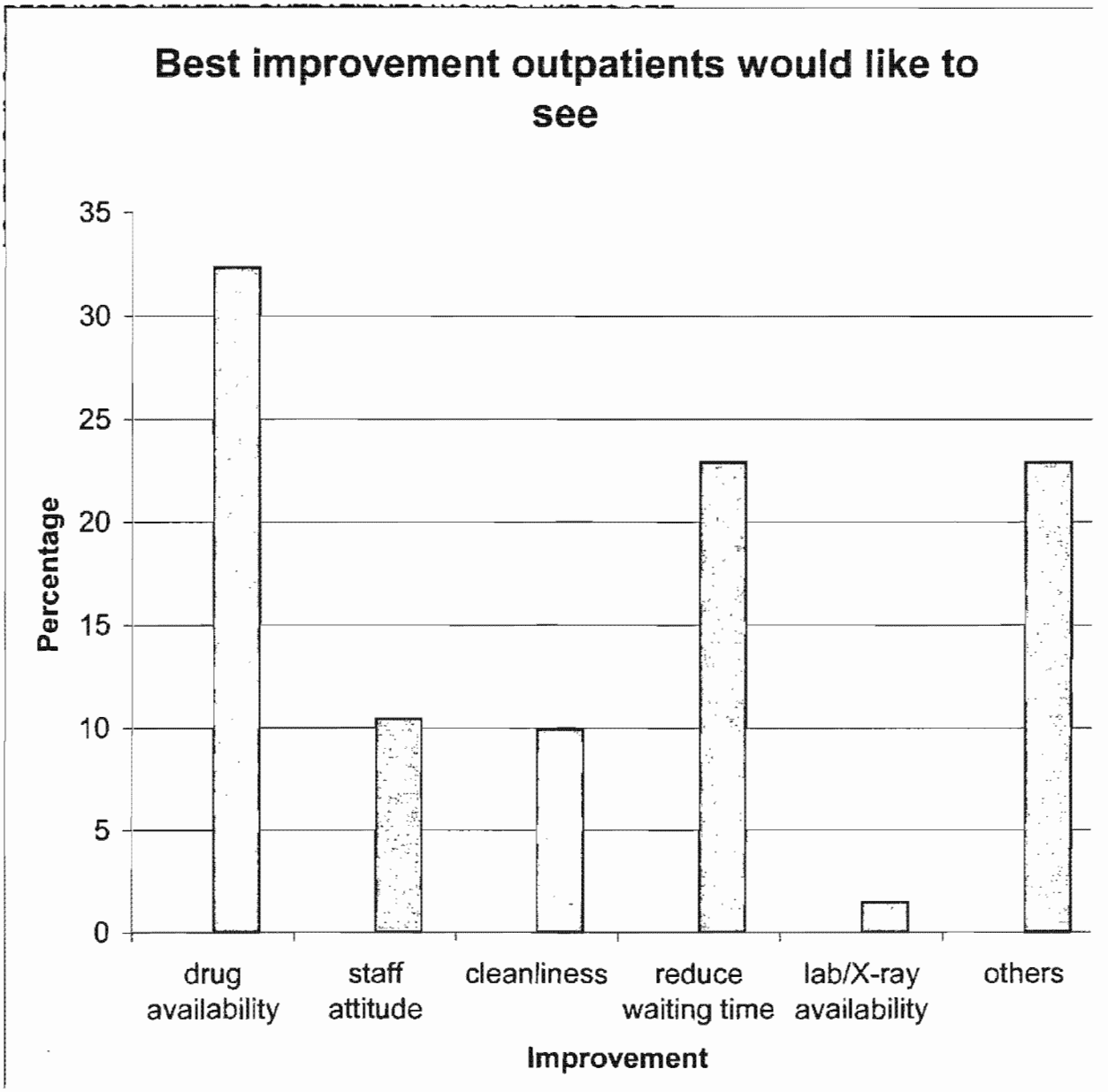


Quality hotel facilities ranked second with a vote of 30.2%. In one of the facilities visited, good bed linens are kept in store, only to be issued when an important visitor(s) arrive. This is absurd.

With respect to the best improvement outpatients would like to see effected, they responded as follows:

Table 17.

The best improvement outpatients would like to see effected.



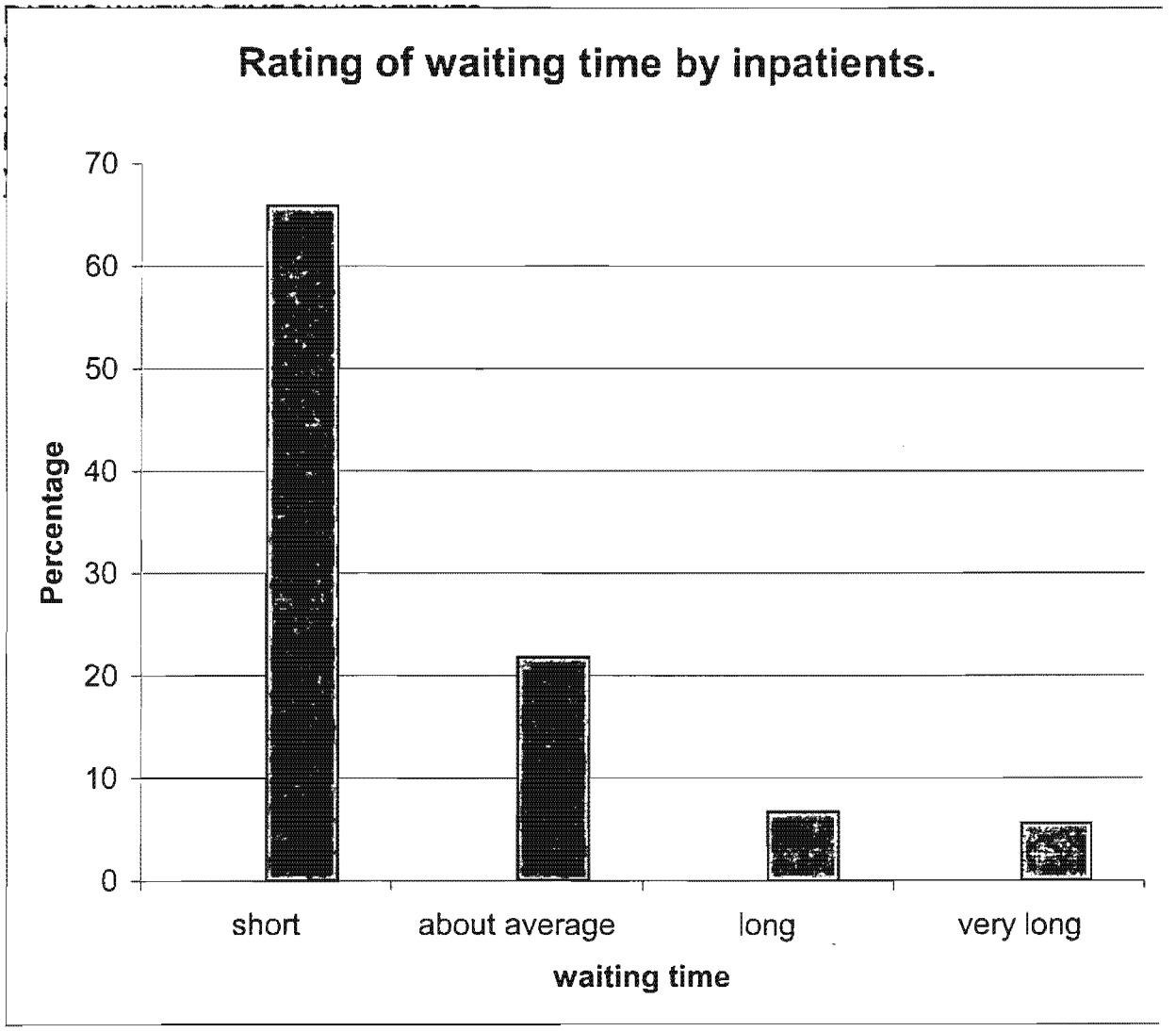
Drug availability ranked the highest, with a vote of 32.34%. This was followed by 'reduce waiting time' with a percentage score of

22.89%. Long waiting time has the potential to deter patients choosing a given provider. Cleanliness was rated poorly by the outpatients with a score of 10%. This may be due to the fact that they only visit the facility for a day, unlike in-patients.

Waiting time is important in assessing the quality of care. Inpatients were asked to rate the waiting time at the facility. The response was as follows:

Table 8.

Rating of waiting time by inpatients.

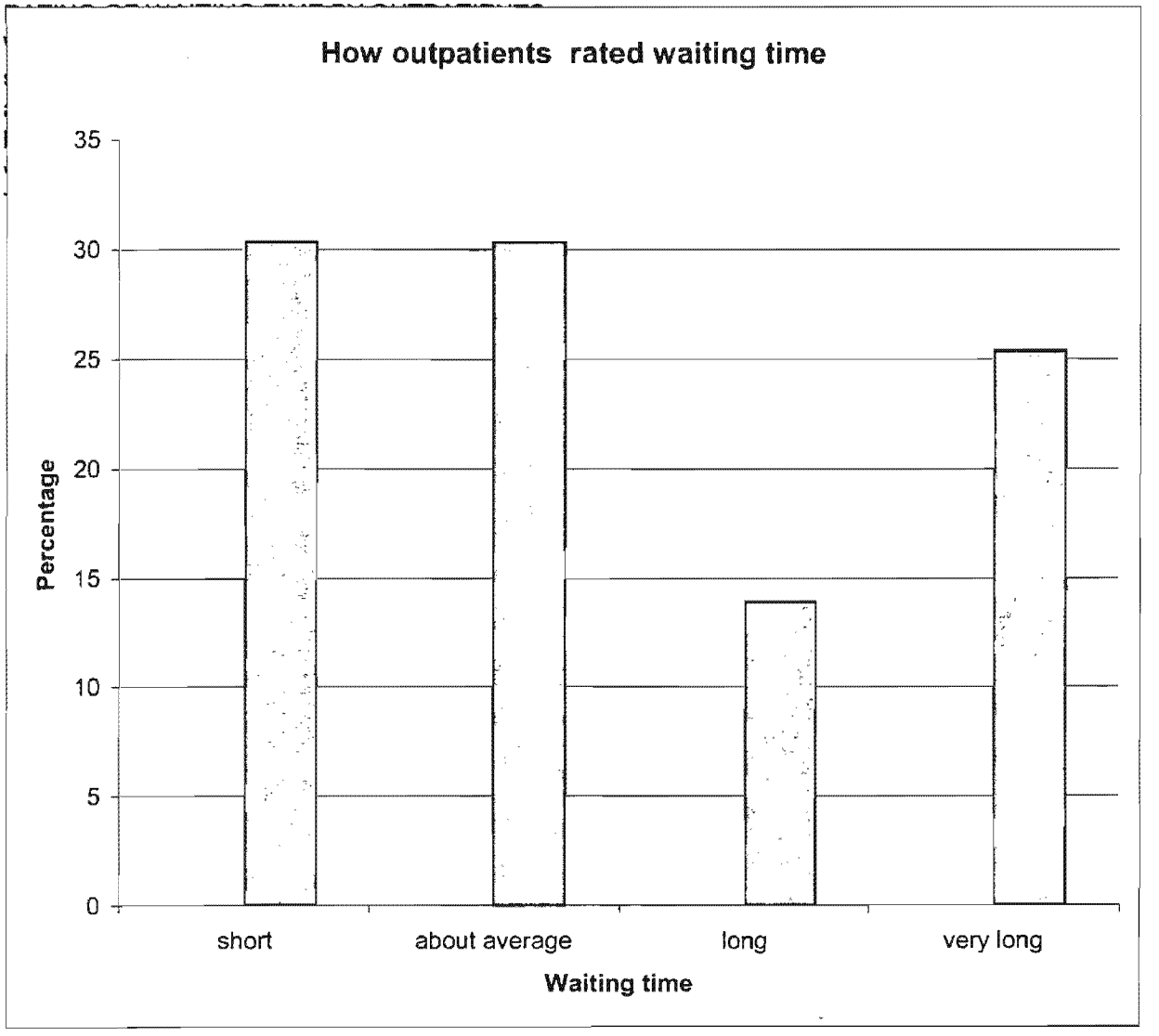


65.9% respondents rated waiting time as short, and 21.79% rated it as 'about average'. This is commendable since only a few rated it as long or very long.

Outpatients were also asked to rate waiting time, see figure below.

Table 9.

Waiting time as rated by outpatients.



The waiting time was rated as short (30.4%) or about average (30.4%). This shows that over 60% of patients responded that waiting time was not long. Yet others said that it was very long. Majority of those who said it was very long were from one facility where few seats are provided at the waiting bay. This is an administration weakness that must be changed. By offering seats at the waiting bay, quality of care perceptions could be boosted without incurring a lot of expense.

6.5. Exemptions and waivers.

Another important issue is the exemption of patients who are not able to pay. Some patients may be denied care because they cannot afford to pay. With this in mind, members of staff (who were in public service before fee implementation) were asked if they have witnessed patients being denied care. About 57% of staff responded that they have witnessed patients being denied care. This goes contrary to the fee policy stipulation that no patient would be denied care due to inability to pay.

In Kenya, the fee policy includes exemptions such as child immunization and antenatal care. Other illnesses with positive public externalities such as tuberculosis and sexually transmitted diseases (HIV/AIDS) are also exempted. 55% of Hospitals' staff respondents suggested that the MOH should extend exemptions/waivers to other chronic diseases such as asthma, diabetes mellitus, hypertension and epilepsy. Such chronic diseases require a protracted period of treatment, and exempting them from payment would be a great relief to patients.

With regard to demographic groups that should be exempted, over 76% of respondents in the provider survey recommended children under 5 years and patients over 75 years old also be exempted. This is fair enough as such people are usually economically unproductive. This will boost equity in health care, ensuring that no one is denied care due to inability to pay. Currently, the policy does not exempt old people, but the hospital professionals and support staff put a relatively high weight on the provision of free care to the old.

An unstructured interview with patients revealed that they do not know exemptions or waivers exist in the fee policy. It is not clear why the MOH is reluctant to advertise exemptions and waivers in the mass media. This may be due to fear of losing the much-needed revenue in this sector.

With regard to disease categories that should be exempted, staff responded as follows:

Table 10.

Patients who should get free treatment

Offer free treatment to	Freq.	Percent	Cum.
HIV/AIDS and chronic illnesses*	66	55.00	55.00
Psychiatric cases	4	3.33	58.33
None (not applicable)	50	41.67	100.00
Total	120	100.00	

* chronic diseases include: athsma, diabetes, hypertension, tuber culosis and epilepsy.

55% of staff were of the opinion that HIV/AIDS and chronic illnesses ought to be treated free of charge. With regard to demographic categories that should be exempted, over 75% of respondents thought under 5s and over 75 year olds should be exempted. No other demographic group received significant support for exemptions. At times of

treatment, it becomes very hard to verify the information given by those patients seeking exemption. When asked who actually verifies such information, the hospital secretaries said that the ward matron who is in direct contact with the patient usually verifies such information but this has to be countersigned by either the hospital secretary or the head nurse. In addition, social workers may also recommend patients for exemption to the hospital administration.

The exemption criteria needs to be constantly reviewed to ensure that no patient is denied care. Survey results indicated that it is not reviewed by MOH. This is an administrative weakness as there is no reason as to why MOH does not review it.

6.6. Equity.

As mentioned in the literature review, the level of fee may deter facility utilisation. Staff who were in service before the fee policy was implemented (and may have witnessed patients being denied care in one way or another) were asked to state how they consider the level of fees. The following was the result:

Table 11.

Fee level.

fee level	Freq.	Percent	Cum.
low	11	22.45	22.45
right level	27	55.10	77.55
high	11	22.45	100.00
Total	49	100.00	

Over 55% of staff think that fees are at the right level. Nevertheless, running of mobile clinics could help towards enhancing equity especially in remote areas. However this has proved to be quite expensive especially where the population density is low. The poor road network compounds this issue especially during the rainy season. In the survey, 70% of staff responded that their facilities do not run mobile clinics. Only Nyeri provincial hospital runs a mobile eye clinic sponsored by the local Lions Club of Kenya. We can conclude that fee revenue is not used to run mobile clinics. This may be a wasted opportunity.

The fees charged at hospitals are not structured such that referred patients pay less fees than the bypassing ones. For instance, at hospital level all outpatients pay the same fee for registration and consultation. This implies that patients who comply with the referral system are overcharged with respect to registration and consultation (they pay both at the lower level facility and the hospital). Bypassing primary level facilities brings inefficiency in facility utilization as those who could be treated effectively at lower level facilities go directly to hospitals. It is recommended here that bypassing patients should be charged a higher fee at the hospital.

As noted in the introduction, hospitals do not necessarily charge the same fees for similar services. Although facilities may not charge exactly the same fees for similar services, significant fee differences are detrimental in facility utilization. Some facilities would be under-utilised and others would be over-utilised. Other things being equal, we would expect patients to prefer low-priced facilities than high-priced ones.

Income levels have a bearing on the health seeking behaviour of patients. In order to have insight about the type of patients who seek

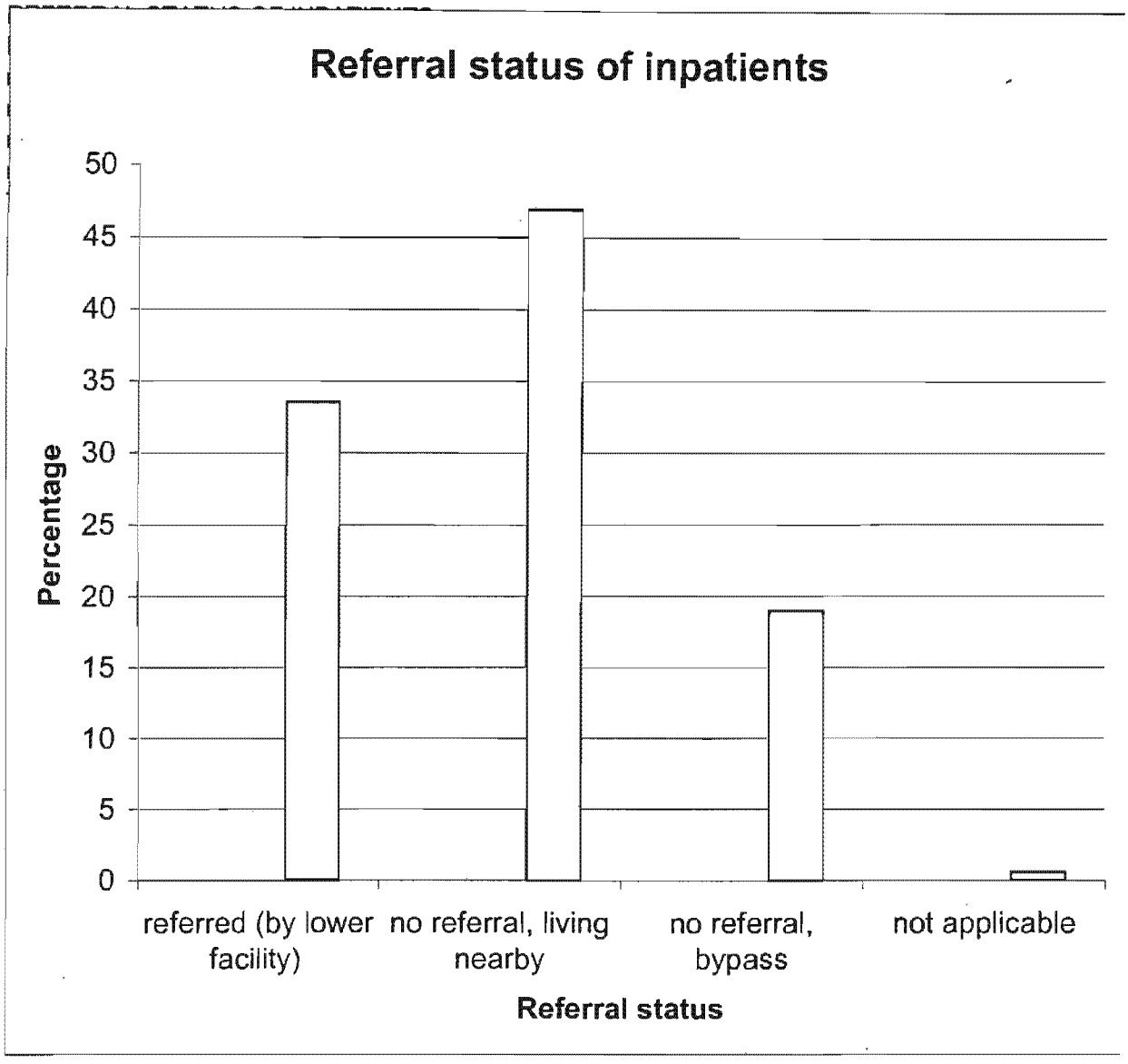
care at public facilities, inpatients were asked to state their income range per month. Over 95% responded that their incomes are below Ksh. 5000 (1US$ = Ksh.72). There were similar results for outpatients. These incomes are quite low.

6.7. Utilisation patterns.

Another important issue is the referral status. Efficiency in facility utilisation could be enhanced if patients comply with the referral system. The inpatients referral responses are shown in Table 12.

Table 12.

Referral status of inpatients.



The majority of the respondents (47%) said that they had no referral status but were living nearby. 34% said that they were referred from a lower level facility. This is quite efficient. Those who by-passed lower level facilities accounted for about 19%.

Many of the outpatients usually seek care from hospital facilities, bypassing lower level facilities. This leads to

inefficiency in facility utilisation as mentioned above. In the survey, over 71% of outpatients were not referred to the hospital from a lower facility. Over 81% said the reason for bypassing a lower facility is that they live nearby. This does not however guarantee them the right to bypass.

To assess if a facility is fairly within reach, outpatients were asked to say how long it took them to arrive at the facility. The average time taken is 47 minutes. See table below:

Table 13.

Time it takes outpatients to get to hospital (minutes).

Variable	Obs	Mean	Std. Dev.	Min	Max
minutes	201	47.60697	40.30818	5	240

The common mode of transport used is motor vehicles (public transport) i.e. over 63% used motor cars or minibuses. See Table 15.

Table 14.

Mode of transport used	Freq.	Percent	Cum.
walking	71	35.32	
bicycle	1	0.50	35.82
motor vehicle	128	63.68	99.50
others	1	0.50	100.00
Total	201	100.00	

Over 35% of patients said they just walked to the facility, further showing that facility is within reach to many. Hence access is not a problem in this area.

6.8. Willingness and ability to pay.

In order to gauge willingness to pay for user charges, inpatients interviewed were asked if they expect to pay for the services they receive. Table 15 shows their responses.

Table 15.

Do inpatients expect to pay for the services received?

Expect to pay?	Freq.	Percent	Cum.
Yes	161	89.94	89.94
no	8	4.47	94.41
don't know	10	5.59	100.00
Total	179	100.00	

About 90% responded that they expect to pay for the services they are receiving. This shows a strong knowledge of the user fee policy. Only a small percentage (4.5%) said that they did not expect to pay. Those who are not certain of whether they would pay accounted for 5.6%. The uncertainty of whether a patient will pay or not may come about due to several factors. For instance if the patient has no source of income, he/she may resort to borrowing or expect to be given a waiver, which are all uncertain.

It is important for policy makers to have a grasp of the willingness to pay and ability to pay for critical health care services. This knowledge is crucial in fixing fee levels. The following summary table relates to inpatients' willingness to pay and ability to pay for improved services.

Table 16.

Inpatients willingness to pay, ability to pay and suggested improvements to services.

Service	Willingness to pay (Ksh.)*	Ability to pay (Ksh.)*	Significant improvement suggested	Willingness to pay for improved services (Ksh.)*
Hotel	82.40	67.90	Offer balanced diet	113.30
X-ray	111.60	94.30	Offer different services	147.60
Lab	79.60	44.30	Speed up service	95.00
Drugs	114.60	73.20	Make available	156.70
Theatre operation	114.30	85.70	Avail different services	128.40
Registration & consultation	20.00	28.50	Reduce waiting time	28.10

* 1US$ = Ksh.72

The above table reveals interesting results for policy makers in terms of willingness to pay and ability to pay for services. The difference between willingness to pay for improved services and the ability to pay is quite high. In case of hotel services, willingness to pay is Ksh. 113.30 and ability to pay is Ksh. 67.90. One way of tackling this is to charge hotel services differentially and let patients select the option that suits them, as suggested by Thomas *et al* (1998). The quality of treatment in all options should be the same. Higher revenues collected from the expensive option may be used to subsidise care from the cheap option. The difference between willingness to pay and ability to pay for important services such as drugs, laboratory, X-ray and theatre operations is quite high (see table above). At best, we can conclude that patients who seek care from public hospitals are low-income earners. This may call for strengthening of exemptions and waiver policy to ensure that no patient is denied medication.

Outpatients were asked to state from where they expect to get money to cover the costs. The majority (38%) said that they expect to get assistance from friends and relatives. This clearly shows the type of people who seek care from public facilities. Close to this was those who said they'd pay from personal savings (36%). The few who said 'others' are among those who said they don't expect to pay. To ascertain if outpatients actually paid for services received or not, they were asked whether they paid for services received. Table 18 shows their response.

Table 18.

Did the patient pay for the services obtained?

paid?	Freq.	Percent	Cum.
yes	172	85.57	85.57
no	29	14.43	100.00
Total	201	100.00	

Over 85% responded that they paid, which is encouraging. Majority of those who did not pay comprised of post-natal services that are usually exempted. On average, the total fee outpatients paid which comprised of registration & consultation, lab & X-ray services, drugs and others were summarised as follows:

Table 19.

Sum of total fee paid (1US$ = Ksh.72).

Variable	Obs	Mean	Std. Dev.	Min	Max
totfee	201	133.2289	290.6245	0	2870

The average fee paid was about Ksh. 133 per patient with a standard deviation of Ksh. 291. This shows that outpatient fee fluctuates greatly, but this is expected due to diversity of services offered.

Although the MOH had initially issued a charge list to the hospitals, the study reveals that they do not necessarily charge the same price for similar services (refer to table at beginning of results section). The District Health Management Boards usually revise charges. High differential charges were noted in maternity, in-patient charge per day

and theatre. As noted earlier in the ability to pay section, those who seek care from public hospitals are low-income earners, thus high fees are likely to be a deterrent to facility utilisation. The policy makers should investigate the effect of such differential charges and take necessary action.

6.9. Cost recovery

In an attempt to determine the net revenue generated by facility per year, costs associated with user fees and revenues generated data were collected. The cost data that were collected for purposes of estimating the net revenue generated were not very accurate. The prices quoted here, therefore, do not reflect cost of, or demand for, services. Before the fee policy was implemented, there was no initial study conducted of the willingness to pay or ability to pay for health care services. The government just fixed the prices and it is not clear if it considered the minimum wage earnings. Lack of such a study may be attributed to political sensitivity over fee policy. In the facilities visited, there was no formal method of costing services. Care should therefore be taken in interpreting the net revenue generated. However, this study gives us some insight towards this end. Further research is needed on service costs to facilitate rate setting. The costs were estimated on monthly basis and then projected for the whole year. The net revenue generated by each of the facility was estimated as shown in table 20.

7.0. Net revenue generated.

Table 20.

Economic (recurrent) costs incurred in fee collection (1US$ = Ksh.72).

Facility costs associated with fee collection	**Monthly costs related to fee administration & collection (Ksh.)**			
	Nyeri	**Murang'a**	**Kiambu**	**Tigoni**
Administrators (gross salary):*				
Hospital secretary	3750	3750	3750	3750
Medical officer of health	4750	4750	4750	4750
Head matron	4250	4250	4250	4250
DHMBs **	1250	1250	1250	1250
Salaries of clerks @ Ksh. 6000	78000	48000	54000	42000
Overheads incurred:***				
Electricity	5899.50	5226.50	6986.30	1239.85
Phone	11950	9950	10350	9750
Cleaning costs	5000	3580	4580	3250
Water bills	15000	10750	13750	9750
Building maintenance	12500	7500	10000	5000
Stationery(includes Ledger & receipt books)	6250	4750	5050	4500
Office rentals equivalent	1000	15500	17500	14500
Cost of computers	-	-	-	-
Banking costs	-	-	-	-

Total fee collection cost per month	149599.50	119256.50	136216.30	103989.85
Total fee collection cost per year	**1795194**	**1431078**	**1634595.60**	**1247878.20**
Total revenue collections	**9539917**	**4786262**	**3702934**	**824482**
Net revenue generated	**7744723**	**3355184**	**2068338.40**	**-423396.20**

* Administrators are assumed to spend ¼ of their time managing fees. An interview with senior hospital administrators revealed that they spend ¼ of their time on fee management.

** DHMBs meet quarterly and spend on average a total of Ksh. 3750 per sitting.

*** Only 5% of cost is assumed to be consumed by fee collection offices, this is in proportion the area occupied by fee offices on average.

Cost recovery is thus very low, accounting for no more than 5% on average. In fact it was negative in Tigoni sub district hospital. Negative cost recovery implies that costs exceeded the revenues generated. This presents a very strong argument against fees - it is not worth it to collect fees in this facility. The question to ask is, how should cost recovery be boosted? There is need to streamline fee administration, especially collection and usage. Official receipts must be issued to patients upon every payment made. It is advisable for the hospital administration to enlighten patients that they should demand official receipts for every payment made. An unstructured interview with patients found out that the low perceived quality of care of public hospitals often made them seek care elsewhere. Thus, if funds

collected could be put into proper usage like procuring drugs, equipping laboratories and theatre, improving on cleanliness and staff attitude, etc, this could improve the perceived quality of care and attract more patients.

7. RECOMMENDATIONS AND FUTURE CHALLENGES.

This study has shown that development of a successful fee policy requires gaining acceptance of the public and providers, retaining much of the revenue generated at facility level to boost quality visibly and enhancing equity by protecting vulnerable groups. In addition to careful design of fee structures and management systems, considerable training and supervision, continuous monitoring of the system and evaluation of performance and impact is important. There is a need to revise resource allocation between hospital based curative care and PHC. Currently, only 25% of hospitals' revenues generated are allocated to PHC. Additional resources (both financial and human) should be channelled to PHC initiatives as they have been found to be cost-effective. Training of low cadre nurses and health workers for PHC will be a step forward in the right direction. Most of the illness and morbidity will be prevented especially in rural areas, which will go a long way in reducing the curative care budget.

The resources needed to carry out a major and sustained fee policy is significant and requires commitment. This study has shown that the benefits of a successful fee policy program can outweigh the costs. However, negative cost recovery ratio like in the case of Tigoni sub district hospital means that costs exceeded revenues. This may suggest weaknesses in fee management practises and poor administration systems that need to be investigated further by MOH. The challenge to

MOH is to improve the efficiency of fee collection such that revenue does not only prevent quality of services from deteriorating, but also improves quality of care. The paying of fees (though small) make patients more demanding in terms of quality and efficiency and this may encourage quality improvement in public facilities in addition to making them appreciate services.

Local management and community involvement that accompanies a successful program can contribute significantly to the decentralisation of health service management. For the District Health Management Board members to be fully accountable to patients, they should be elected directly by the people rather than handpicking them. This study has shown that much remains to be done for the program to work effectively. Supply of essential drugs and other improvements as suggested in this study must be effected for the user fee policy to succeed. Thus, the sustainability of the fee programme is not only dependent on ensuring that the benefits/revenue actually exceed the costs of collection, but on translating this revenue gain in to service quality gains. The challenge is to continue strengthening and developing systems in a way that generates increasing revenues while ensuring that the vulnerable groups are protected. Better management practises at the facility level might not only lead to increased revenue but also may lower the costs of services. In order to strengthen the referral system, bypassing patients should be penalised by charging them higher fees. The following measures are also suggested to try and strengthen the user fee policy:

1. MOH should hold seminars (say on annual basis) to educate staff on the challenges that continue to face the fee policy. Such

seminars are important venues for MOH staff to learn and share experiences, discuss problems and suggest ways to tackle them. This way, facilities that continue to perform poorly can learn fee management techniques from others. The policy makers at MOH headquarters can utilise such venues to praise efficient facilities and encourage weaker ones. MOH policy makers can also award certificates of merit to excelling facilities. This will trigger competition among facilities, which is a sign of good management practices.

2. To boost transparency and accountability, independent auditors should be employed (or re-deployed) to act as watch dogs in fee collection and usage. This would ensure proper recording of all cash received and expended and minimise pilferage. MOH has a duty to ensure that those officers who misuse fee revenue are punished in accordance with the law (which should be made clear to staff).

3. An attempt should be made to make hospitals more autonomous with respect to fee collection and usage as long as they act within the MOH laid down policy guidelines. MOH must continue to control and regulate user charges in an attempt to ensure that patients are not overcharged in an attempt to generate more revenue. This will go a long way in ensuring that health care is made available to patients, as we saw that those that use public facilities are generally low-income earners. With regard to revenue usage, for instance, hospitals may be encouraged to operate own pharmacies where patients can buy drugs at fair prices. Currently patients are being referred to private chemists and stores that are expensive. Hospital pharmacies may enjoy economies of scale due

to bulk buying and therefore can offer drugs cheaply. It was disheartening to see patients being sent to buy gloves, dressing wool, etc. from private stores while these could be provided cheaply at the hospital. However regulatory mechanisms need to be put into place to ensure that operation of such hospital pharmacies are not abused.

The study concludes by emphasising that with proper policy guidelines and administration, user fee policy has the potential to contribute significantly to the funding of government health services, without significantly reducing access for the poor.

8. APPENDIX.

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8.2. TERMS AND CONCEPTS USED.

1. Cost sharing

Sharing the costs of providing a particular type of health care between the patient and agencies such as the provider of care and/or the employer of the patient.

2. Cost-effective

This term denotes a situation, when for a given output the cost of producing such output is minimised. In other words, for a given cost the output is maximised. It essentially embodies technical efficiency and is a supply-side concept.

In economics, one can talk of cost-effective when the isocost line is tangential to an isoquant (Culyer, 1989).

3. Cost recovery

Refers to the money receipt, by a health provider from patient(s) or the community in exchange for health services. It may be expressed as a percentage of the expenditure (Kinnon et al. 1994).

4. Efficiency

4.1. Allocative efficiency

Refers to employing productive inputs in optimal proportions given their prices and productivity at the margin. In health economics, Allocative efficiency exists if we pursue health care programs that are worthwhile (i.e. marginal benefits exceed marginal cost).

4.2. Technical efficiency.

Is the extent to which production inputs (e.g. labour, drugs, equipment etc.) are combined in a way that yields the maximum feasible output. Technical efficiency involves the selection between alternative means of achieving the same ends, and may therefore be interpreted as the pursuit of maximum output for a given bundle of inputs (ibid.). In economics to be technically efficient means to be located on an isoquant.

5. Equity

Equity means fairness or justice. It incorporates the idea of social justice where resources and benefits are distributed fairly. We can talk of vertical equity or horizontal equity. The former refers to the extent to which unequal individuals should be treated unequally. Horizontal equity is concerned with equal treatment of equals in the society. For purposes of this study, equity is used to imply equal access to health care for equal need.

6. Exemption

This refers to an excuse from payment based on either the patient's age, illness (such as tuberculosis), or use of a specific preventive service, such as antenatal care (Quick *et al* 1993). Though practically hard to determine, Income levels or wealth can also be used to determine eligibility for exemption.

7. Financing methods.

Ways of raising financial (and sometimes other) resources to provide services. Financing methods include fee-for-service, insurance schemes and payroll taxes.

8. Externality

Externalities exist when the level of consumption or production of some good or service by a consumer or firm has a direct effect on the level of welfare of another consumer or firm, as opposed to an indirect effect through the price mechanism. These effects may be desirable or undesirable. An often-quoted example in the health field is the protection against disease provided to others when an individual is immunised.

9. Fee-for-service

Refers to payment per unit (episode) of health care received (e.g. Consultation, drug, diagnostic test etc.).

10. Financing sources

Refers to the origin of the financial resources used to provide services. Sources include conventional taxes, individuals, commercial and industrial organisations and external donors.

11. Free market

A market in which the forces of supply and demand are allowed to operate unhampered by government regulation or other interference. In this way, the forces of supply and demand fix the price of a good or service.

12. Means testing

This is a targeting mechanism, which helps to classify specific individuals as eligible or ineligible for subsidies or benefits (e.g. fee waivers) according to income or wealth-related criteria. The purpose of means testing in the health sector is usually to release totally or partially from payment (by the poor), or those who would suffer undue financial hardship by paying (Willis and Leighton 1995).

13. Real terms

A variable (such as national income, or health expenditure) is expressed in 'real terms' if its value has been adjusted to remove the effect of changes in price. The resulting value is said to be at a constant price.

14. Targeting

This is the general process of channelling benefits such as subsidised health care to a target population such as the poor, females or children (Willis and Leighton 1995). Means testing is a powerful way of boosting equity in health care.

15. User fees

These are charges levied on the patient or client for any aspect of health care, including consultation, drugs and other services (rendered by public providers). The term is synonymously used with user charges, where users of a service are required to pay a fee.

16. Waiver

A discretionary release from payment based on inability to pay (Quick *et al* 1993).

17. Time cost

The cost individuals incur in being inactive through illness or in travelling to and waiting for health services. Time cost can be explained in terms of its opportunity cost foregone (i.e. Value of lost production/leisure) when one is seeking treatment.

8.4. QUESTIONNAIRE FOR COLLECTING DATA FROM HEALTH WORKERS

Dear respondent,

This questionnaire is designed to collect data for the purpose of evaluating the user fee policy for health care in Kenya that has been in existence since December 1989. The views of health professionals are of paramount importance in assessing whether the scheme is meeting its intended objectives or not and institute some remedial measures where necessary. Therefore your input in this regard is highly appreciated. Please extend your cooperation by expressing your views to the questions asked. We assure you that the information that you provide will be treated as confidential.

Thank you for your cooperation.

SECTION A: ABOUT THE RESPONDENT IN THE HOSPITAL

To which professional group do you belong?
(write appropriate number in the box). ☐

1 = Medical doctor
2 = Nurse
3 = Assistant nurse / health assistant
4 = Pharmacist
5 = X- ray technician / Lab technician
10 = Others (specify)

_____

_____

SECTION B: USER FEE POLICY QUESTIONS.

1. Are you aware of the user fee policy objectives in Kenya? ☐

1 = Yes
2 = No

2. In your opinion, what do you think is the most important objective of the user fee policy in Kenya? (choose only one). ☐

1 = generate revenue (income)
2 = improve quality of services
3 = improve accessibility to underserved areas
4 = improve the health status of the population
99= others (specify)

_____

_____

3. Have you ever attended Seminars / workshops on the user fee policy? ☐

1 = Yes
2 = No

4. Were you in public service before user fees were implemented? ☐

1 = Yes
2 = No

19. If the answer to question 14 is "No" (ie. if the patient does not expect to pay out of pocket for the serevices she/he is receiving) what is the reason? ☐

1 = exemption
2 = waiver with a certificate
3 = waiver but no certificate
4 = deductions to be made from salary
5 = insured
99 = others (specify) _____

If answer to question 19 *is* "2" *ie. "waiver has certificate" answer question* 20 & 21; *Otherwise go to question* 22.

20. From where did you (she/he) get the certificate?

_____

_____

21. How long did it take you (him/her) to get it?

_____

_____

22. How much would you be willing to pay, given the quality of service that you are receiving from this hospital?

a) Hotel costs (per day) Ksh._____

b) X-ray examinations Ksh._____

c) Laboratory tests Ksh._____

d) Drugs Ksh._____

e) Operation (if patient had one, state type of operation from the clinical card) Ksh._____ _____

23(a). How would you like to see the quality of service improved with regard to:

(a) Hotel costs?

_____

_____

_____

_____

5c) increased availability of essential drugs

1 = yes 2 = no 3 = don't know

5d) increased service (treatment) time for clients

1 = yes 2 = no 3 = don't know

5e) improved care (medical, nursing, etc) time for clients

1 = yes 2 = no 3 = don't know

5f) increased availability of essential diagnostic examinations

1 = yes 2 = no 3 = don't know

5g) increase in the number of clients coming with a referral slip

1 = yes 2 = no 3 = don't know

6. In your practise, do you encounter clients, who, because of inability to pay could not obtain the necessary service

1 = yes 2 = no

7. If your answer to question 6 is "**yes**" , how do you describe the magnitude of the problem?

1 = mild 2 = serious 3 = very serious

8. In your opinion, do you think clients should pay for the health services that they obtain from your facility in the following areas:

8a) Consultation

1 = yes 2 = no 3 = don't know

8b) Drugs

1 = yes 2 = no 3 = don't know

8c) Hospitalisation

1 = yes 2 = no 3 = don't know

8d) Diagnostic tests

1 = yes 2 = no 3 = don't know

(If your answer to question 6 is "**yes**" , please answer question 9 otherwise go to question 10).

9. What do you think about the level of fees?

1 = Low
2 = right level
3 = high

10. Which diseases are currently treated free of charge?

_____

_____

_____

_____

_____

10. Which group of clients do you think should be provided services free of charge?

a) disease categories (which other diseases do you think should be treated free of charge?

_____

_____

_____

_____

b) Socio-economic groups (e.g. income groups)

_____

_____

_____

c) Demographic groups (age groups, gender, occupational groups etc)

_____

_____

_____

11. How do you rate the quality of service in your hospital in the following areas? (please tick √ the relevant box)

	Excellent	Good	Fair	Poor	don't know
Availability of drugs					
Competence of staff					
Attitude of staff to patients					
Cleanliness of rooms, toilets etc.					
Appearance of buildings (well painted, good repair)					
Availability of laboratory services					
Availability of X-ray services					
Privacy during examination and treatment					
Availability of adequate bed space					
Availability of adequate bed linen and blankets					
Availability and quality of food					
Overall quality of services at this facility					

12. What is the most important thing would you prefer to see improved at this hospital? (only one)

_____

_____

13. Are there any other specific issues that you feel should be taken into consideration in developing user fee policy for Public Sector health Services?

_____

_____

_____

14. What would be your recommendation to the Ministry of Health concerning the user fee policy?

_____

_____

_____

_____

_____

15. Is determination of eligibility for exemption done in advance so that uncertainty about the fee will not discourage utilization?

1 = yes
2 = no
3 = don't know

16. Sometimes patient(s) seeking exemption may give false information. Who verifies such information?

_____

_____

_____

17. Do your hospital run mobile clinics?

1 = yes
2 = no
3 = don't know

18. If your answer to question 17 is "yes" , is user fee revenue used to finance mobile clinics?

1 = yes
2 = no
3 = don't know

19. Does the Ministry of Health (MOH) review the exemptions criteria regularly?
If it does, how regularly? _____

_____

_____

Thank you for your cooperation in completing this questionnaire.

KENYA USER FEE POLICY STYDY

SCHEDULE FOR INPATIENT INTERVIEWS

Name of hospital _____

Type of ward (choose one below).

1. pediatric
2. medical (adult)
3. surgical (adult)
4. maternity.
99. others (specify)_____

To the interviewee,

This interview schedule is designed to collect data for the purpose of evaluating the user fee policy that has been in existence since December 1989. The views of consumers of health care services are of paramount importance in assessing whether the fees are meeting the intended objectives or not and institute some remedial measures where necessary. Therefore, your input in this regard is highly appreciated. Please extend your cooperation by expressing your views to the questions asked. We assure you that the information you provide will be treated as confidential.

Thank you for your cooperation.

Interviewer _____

Date of interview _____

Patient identification (from record)

1. Name : _____

2. Age :
   1 = less than 5 years
   2 = 5 - 14 years
   3 = 15 - 44 years
   4 = 45 - 64 years
   5 = 65 +

3. Gender :
   1 = Male
   2 = Female

4. Residence address

_____

_____

5. Occupation :

   1 = work for pay
   2 = self employed
   3 = work at home, no pay
   4 = unemployed
   5 = sick / disabled
   6 = studying / schooling
   7 = others (specify below)

_____

6. **Estimated average household income:**

   a) Salaries and wages (of all household members) Ksh._____

   b) Income from other sources (agriculture, trade, transfers, etc.) Ksh._____

7. What would you say your income range per month is?
   1 = no income
   2 = below Ksh. 1,000
   3 = 1,001 - 5,000
   4 = 5,001 - 15,000
   5 = 15,001 - 25,000
   6 = 25,001 - 35,000
   7 = over 35,000

ILLNESS AND SERVICE UTILIZATION QUESTIONS:

8. How sick do you (she/he) feel? Would you say that you (she/he) feel

1 = not sick
2 = mildly sick
3 = moderately sick
4 = severely sick

9.Referral status:

1 = referred
2 = no referral - living nearby
3 = no referral - bypass
4 = not applicable

10. If referred, indicate level of referring facility

1 = Dispensary
2 = Health centre
3 = Private for profit facility
4 = Private not for profit (eg. Mission hospital)
99 = Others (specify)

_____

11. If the answer to question 9 is "no referral - bypass" what are the reasons for by passing the appropriate health facility?

1 = long waiting time
2 = no drugs
3 = no diagnostics (laboratory, X-ray etc.)
4 = incompetent health workers
5 = others (specify)

_____

12. How do you rate the quality of service in your hospital in the following areas? (please tick √ the relevant box)

	Excellent	Good	Fair	Poor	don't know
Availability of drugs					
Competence of staff					
Attitude of staff to patients					
Cleanliness of rooms, toilets etc.					
Appearance of buildings (well painted, good repair)					
Availability of laboratory services					
Availability of X-ray services					
Privacy during examination and treatment					
Availability of adequate bed space					
Availability of adequate bed linen and blankets					
Availability and quality of food					
Overall quality of services at this facility					

What one thing would you most like to see improved about services at this hospital? (only one):

_____

13. How would you rate the waiting time in being admitted at this hospital?

1 = short
2 = about average
3 = long
4 = very long

FEES AND EXEMPTIONS

14. Do you expect to pay for the services you are receiving in this hospital? ☐

1 = yes
2 = no
3 = don't know

(If "Yes" answer questions 15 - 18 ; if "No" go to 19.

15. How many Ksh. do you expect to pay?

Ksh. _____

Don't know _____

16. How many Ksh. do you expect to pay for each laboratory test?

Ksh. _____

Don't know _____

17. How many Ksh. do you expect to pay for each X-ray test?

Ksh. _____

Don't know _____

18. From where will you (she/he) get the money to cover the cost? ☐

1 = personal savings
2 = borrowing
3 = selling assets
4 = assistance from friends, relatives, etc.
5 = others (specify)

_____

19. If the answer to question 14 is "No" (ie. if the patient does not expect to pay out of pocket for the serevices she/he is receiving) what is the reason?

1 = exemption
2 = waiver with a certificate
3 = waiver but no certificate
4 = deductions to be made from salary
5 = insured
99 = others (specify) _____

If answer to question 19 *is* "2" *ie. "waiver has certificate" answer question* 20 & 21; *Otherwise go to question* 22.

20. From where did you (she/he) get the certificate?

_____

_____

21. How long did it take you (him/her) to get it?

_____

_____

22. How much would you be willing to pay, given the quality of service that you are receiving from this hospital?

a) Hotel costs (per day) Ksh._____

b) X-ray examinations Ksh._____

c) Laboratory tests Ksh._____

d) Drugs Ksh._____

e) Operation (if patient had one, state type of operation from the clinical card) Ksh._____ _____

23(a). How would you like to see the quality of service improved with regard to:

(a) Hotel costs?

_____

_____

_____

_____

(b) X-ray examinations?

(c) Drugs?

(d) Operations? (if patient had one, state type of operation from the clinical card)

23(b). If the quality of service rendered is to be improved in tbe way you have suggested,

[1] how much would you be willing to pay for:-

a) Hotel costs (per day) Ksh._____

b) X-ray examinations Ksh._____

c) Laboratory tests Ksh._____

d) Drugs Ksh._____

e) Operation (if patient had one, state type of operation from the clinical card)

Ksh._____

[2] How much would you be able to pay for:-

a) Hotel costs (per day) Ksh._____

b) X-ray examinations Ksh._____

c) Laboratory tests Ksh._____

d) Drugs Ksh

e) Operations (if the patient had one, state the type of operation from clinical card) Ksh._____

f) deliveries Ksh._____

Thank you very much for your cooperation.

KENYAN USER FEE POLICY STUDY

SCHEDULE FOR HOSPITAL EXIT INTERVIEWS

Name of Hospital _____

_____

Dear interviewee,

This interview schedule is designed to collect data for the purpose of evaluating the user fee policy that was implemented in December 1989. The views of consumers of health care services are of paramount importance in assessing whether the fees are meeting the intended objectives or not and institute some remedial measures where necessary. Therefore, your input in this regard is highly appreciated. Please extend your cooperation by expressing your views to the questions asked. We assure you that the information you provide will be treated as confidential.

Thank you for your cooperation.

Note to the interviewer: questions are to be asked to the guardian if the patient is under 15 years old.

Interviewer _____

Date of interview _____

ILLNESS AND HEALTH SERVICE UTILIZATION

1. Are you referred to this facility by another health institution? (ask if the patient came with a referral slip). ☐

   1 = yes
   2 = no

2. If your answer to question 1 is "No" , I bypassed the nearby health institution. What is the one most important reason for not using the nearby health facility? (do not prompt) ☐

   1 = Long waiting time
   2 = no drugs
   3 = no diagnostic (laboratory, X-ray)
   4 = incompetent health workers
   5 = Others (specify) _____

3. How sick do you (she/he) feel ? Would you say you (she/he) feel : ☐

   1 = not sick
   2 = mildly sick
   3 = mederately sick
   4 = very sick

4. How would you rate the waiting time at this hospital? ☐

   1 = short
   2 = about average
   3 = long
   4 = very long

SOCIO-DEMOGRAPHICS

1. Age of patient (in years) : ☐

   1 = less than 1 year
   2 = [1 - 4]
   3 = [5 - 14]
   4 = [15 - 44]
   5 = [45 - 64]
   6 = [65 +]

2. Gender of patient : ☐

   1 = male
   2 = female

3. If the patient is under 15, what is the relationship between patient and the caretaker / respondent? ☐

   1 = father
   2 = mother
   3 = brother / sister
   99 = others (specify) _____

4. How many minutes did it take you to arrive at this hospital?

   _____ minutes

5. What mode of transport did you use to get to this hospital? ☐

   1 = walking
   2 = bicycle
   3 = motor vehicle
   99 = others (specify) _____

6. Residential address of patient (record only the location & division)

   _____ Location

   _____ Division

7. What type of work does the ill person do?

1 = work for pay
2 = self employed
3 = work at home, no pay
4 = unemployed
5 = sick / disabled
6 = studying / schooling
7 = others (specify) _____

8. What would you say your income range per month is?

1 = no income
2 = below Ksh. 1,000
3 = 1,001 - 5,000
4 = 5,001 - 15,000
5 = 15,001 - 25,000
6 = 25,001 - 35,000
7 = over 35,000

9. How would you rate the following features of this hospital?
(tick √ in the relevant box).

	Excellent	Good	Fair	Poor	don't know
Availability of drugs					
Competence of staff					
Attitude of staff to patients					
Cleanliness of rooms, toilets etc.					
Appearance of buildings (well painted, good repair)					
Availability of laboratory services					
Availability of X-ray services					
Privacy during examination and treatment					
Overall quality of services at this facility					

10. What one thing would you most like to see improved at this hospital? (only one)

_____

_____

FEES AND EXEMPTIONS

10. Did you pay (she/he) for the services that you (she/he) obtained from this hospital? ☐

1 = yes
2 = no

(If your answer to question 10 is "Yes" answer question 11 & 12). otherwise fo to question 13.

11. How much did you pay for the services? (fill in the following table).

Service	**Amount paid (Ksh.)**
registration & consultation	
laboratory tests	
X-ray examination	
drugs	
others (specify)	

What is the most important thing would you like to see improved at this hospital? (only one).

_____

_____

12. Where did you (she/he) get the money to pay for the services? ☐

1 = personal savings
2 = borrowing
3 = sold personal belongings
4 = got assistance from relatives, friends etc.
99 = others (specify) _____

13. Why didn't you (she/he) have to pay for the services?
(this refers to on the spot payment)

1 = exemption
2 = waiver with a certificate
3 = waiver but no certificate
4 = deductions to be made from salary
5 = insured
99 = others (specify) _____

_____

(If answer to question 13 is "waiver with a certificate" , answer 14 and 15: otherwise go to question 16).

14. From where did you (she/he) get the waiver certificate?

_____

_____

15. How many days did it take you (her/him) to get it?

_____ days.

16. Will you buy all the drugs prescribed to you ?
(If drugs are to be bought from private pharmacy)

1 = yes
2 = no
3 = don't know

17(a). Given the quality of service that you obtained from this hospital, how much would you be willing to pay for :

a) registration and consultation? Ksh. _____

b) drugs? Ksh. _____

c) diagnostic tests?

Type of test	**Willingness to pay in Ksh.**

17(b). What improvements would you like to see in this hospital with regard to:

(I) registration and consultancy?

_____

_____

_____

_____

(2) drugs?

_____

_____

_____

_____

(3) diagnostic tests?

Type of test	Improvements
X-ray	----------
Lab	----------

18. If the quality of service rendered is to be improved in the way you suggested, how much would you be willing to pay for:-

a) registration and consultation? Ksh. _____

b) drugs? Ksh. _____

c) diagnostic tests?

Type of test	**Willingness to pay in Ksh.**
_____	_____
_____	_____
_____	_____

19. What is the estimated average monthly income of your household? ☐

1 = no income
2 = below Ksh. 1,000
3 = 1,001 - 5,000
4 = 5,001 - 15,000
5 = 15,001 - 25,000
6 = 25,001 - 35,000
7 = over 35,000

20. To which income group would you classify yourself? ☐

1 = low
2 = middle
3 = high
4 = don't know

21. Based on the monthly income and personal savings of your family, how much would you be able to pay for :

a) registration and consultation? Ksh._____

b) drugs? Ksh._____

Type of test	**Willingness to pay in Ksh.**

Thank you for your cooperation