An investigation of the Factors Influencing the Choice of Health Care Financing by Informal Sector Entrepreneurs in Nakuru Town

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A Research Project Submitted in Partial fulfillment of the requirements of the degree of Master of Business Administration (Finance), School of Business, Kenyatta University

NOVEMBER 2012

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An investigation of the factors
DECLARATION

I hereby declare that this research project is my original work and has not been submitted to any other university for examination.

Date: 15/11/2012

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

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Chairman

Department of Accounting and Finance
DEDICATION

This study is dedicated to my parents Mr. and Mrs. Maubi, My wife Stellah and my two young children Kerubo and Getuba for always wishing me the best, and encouraging me endlessly.
ACKNOWLEDGEMENT

Special thanks to my supervisor for his valued guidance, support and direction. His academic critique and extensive discussion highly inspired my writing to produce more than just the academic output. I also thank colleagues, who gave me tremendous insights and encouragement, and were very instrumental in making the research proposal a success.
# TABLE OF CONTENTS

**DECLARATION** ................................................................................................................................. ii  
**DEDICATION** .................................................................................................................................... iii  
**ACKNOWLEDGEMENT** ......................................................................................................................... iv  
**TABLE OF CONTENTS** ....................................................................................................................... v  
**LIST OF ABBREVIATIONS** ................................................................................................................... viii  
**ABSTRACT** ......................................................................................................................................... ix  
**LIST OF TABLES** ............................................................................................................................... x  
**LIST OF FIGURES** .............................................................................................................................. xi  

**CHAPTER ONE** ................................................................................................................................. 1  
  1.0 Introduction ...................................................................................................................................... 1  
  1.1 Background of the Study .................................................................................................................... 1  
  1.2 Statement of the Problem .................................................................................................................. 6  
  1.3 Objectives of the Study ..................................................................................................................... 7  
    1.3.1 Specific Objectives ...................................................................................................................... 7  
  1.4 Research Questions ........................................................................................................................... 8  
  1.5 Significance of the Study .................................................................................................................. 8  
  1.6 Scope of the Study ............................................................................................................................ 10  
  1.7 Limitations of the Study ................................................................................................................... 10  

**CHAPTER TWO** ................................................................................................................................. 12  
  2.0 Literature review .............................................................................................................................. 12  
  2.1 Introduction ...................................................................................................................................... 12  
    2.1.1 Health Care Financing in Kenya .............................................................................................. 13  
  2.2 General literature review .................................................................................................................. 16  
    2.2.1 Mechanisms of Health care financing in Kenya .................................................................... 16  
      2.2.2 Health Care Financing In Kenya ...................................................................................... 20  
      2.2.3 National Hospital Insurance Fund .................................................................................. 22  
  2.3 Empirical literature ............................................................................................................................ 26  
    2.3.1 Health Financing and Politics ............................................................................................... 26
# LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AKI</td>
<td>Association of Kenya Insurers’</td>
</tr>
<tr>
<td>ALICO</td>
<td>American Life Insurance Company</td>
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<tr>
<td>CBHI</td>
<td>Community Based Health insurance</td>
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<tr>
<td>CBS</td>
<td>Central Bureau of Statistics</td>
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<td>HMOs</td>
<td>Health Management Organizations</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<td>NGOs</td>
<td>Non Governmental Organizations</td>
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<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for Social Scientists</td>
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<tr>
<td>US/USA</td>
<td>United States of America</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<tr>
<td>KNBS</td>
<td>Kenya National Bureau of Statistics</td>
</tr>
</tbody>
</table>
ABSTRACT

One of the biggest challenges to social health insurance in developing countries like Kenya is the integration of the expanding informal sector and inclusion of the poor. The importance of extending social protection in health to the whole population has gathered momentum internationally. The general objective of the study was to investigate the factors that influence health care financing by informal sector employees. The main purpose of the study was to investigate the factors that affect the choice of health care financing by the informal sector employees. The main objectives of the study was to evaluate the attitudes and beliefs of informal sector contributors towards financing their own health care in Kenya, to know if informal sector employees are responsible for financing their own health care and to know those demographic issues that have high influence on informal sector contributors towards financing their own health care in Kenya. The study was centered on the factors influencing the Choice of Health Care Financing by Informal Sector Employees with Nakuru Town. The research took place as from July 2012 to November 2012. A population of 380 informal sector employees and owners of business enterprises were targeted by the study. This research was carried out by use of surveys. The research applied stratified and snowballing sampling techniques to arrive at a sample size of 380 informal sector employees and owners of business enterprises (operators). The sample was selected using both snowballing sampling method and at random. The study used primary data collection method via a questionnaire to collect data on factors influencing health care financing decisions by the informal sector operators. The researcher approached the respondents and requests them to participate in the survey. The data that was collected was recorded in tables to analyze the data; average scores for the responses per item was calculated. After completion of the research, research the findings was published and copies distributed among the university libraries, health insurance providers, government office (Ministry of Health) and the national library, employers and employees in the informal sector thus elevating the people's living. In summary, the choice of health care financing is influenced by various factors but to different levels. Some of the factors that were thought to influence health care financing include: behavioural factors, economic factors, social factors, spatial and environmental and customer-oriented design features. It can also be concluded that there are other reasons why most informal workers in Kenya fail to contribute to their Health care financing including the price, perceived value of health care, risk aversion, individuals' income, education and employment. Unemployment and income are also a key determinant on the decision of health care financing method. Demand for health insurance increases as personal income increases. Adequate health care financing correlates with high quality health care services provided to a person and this determines performance of health system. The weaknesses in health care financing have greatly affected access by the poor to effective health interventions it is thus necessary for the government to ensure that there is adequate health care financing to all Kenyans. Since the Ministry of Public Health and Ministry of Medical Services are the main coordinators of provision of health services in Kenyans through network of dispensaries, health centres, church missions, industrial health units, district, and provincial and national referral hospitals they should be at the forefront in enlightening entrepreneurs on the benefits of having a choice on health financing and how they can join health care financing programs.
LIST OF TABLES

Table 4.1 Response rate .................................................................47
Table 4.2 The average cost of getting treatment .......................................54
Table 4.3 Extent to which Customer-oriented design features influence the choice of health care financing by informal sector entrepreneurs .................................................................56
Table 4.4 Extent to which social factors influence the choice of health care financing by informal sector entrepreneurs .................................................................57
Table 4.5 Extent to which spatial and environmental factors influence the choice of health care financing .................................................................58
Table 4.6 Extent to which behavioural factors influence the choice of health care financing .................................................................60
LIST OF FIGURES

Figure 4.2 Age ................................................................. 48
Figure 4.2 Level of education ........................................... 49
Figure 4.3 Marital Status .................................................... 50
Figure 4.4 Household incomes in Kenya Shillings .................. 51
Figure 4.6 Where Respondents Live ................................. 53
LIST OF TABLES

Table 4.1 Response rate.................................................................47
Table 4.2 The average cost of getting treatment.............................54
Table 4.3 Extent to which Customer-oriented design features influence the choice of health care financing by informal sector entrepreneurs...........................................56
Table 4.4 Extent to which social factors influence the choice of health care financing by informal sector entrepreneurs...............................................................57
Table 4.5 Extent to which spatial and environmental factors influence the choice of health care financing..............................................................58
Table 4.6 Extent to which behavioural factors influence the choice of health care financing.................................................................60
LIST OF FIGURES

Figure 4.2 Age ................................................................................................................. 48

Figure 4.2 Level of education ......................................................................................... 49

Figure 4.3 Marital Status ............................................................................................... 50

Figure 4.4 Household incomes in Kenya Shillings ....................................................... 51

Figure 4.6 Where Respondents Live ............................................................................. 53
CHAPTER ONE

1.0 Introduction

This chapter gives a background of the study, statement of the problem, research objectives and questions, scope of the study, limitations of the study and the significance of the study.

1.1 Background of the Study

One of the biggest challenges to social health insurance in developing countries like Kenya is the integration of the expanding informal sector and inclusion of the poor. The importance of extending social protection in health to the whole population has gathered momentum internationally (ILO, 2001a, 2001b; Carrin and Preker, 2004; WHA, 2005; Gottret and Schieber, 2006). This is in order to reduce financial barriers to health care services for the needy and to avoid catastrophic health expenditures (Kawabata et al., 2002).

The informal sector can be defined as economic units involved in production of goods and services in order to create jobs and incomes on a small scale, with a low level of organization and a weak division between work and capital. The informal sector is characterized by low and non-regular, non-taxed incomes, insecure employment and self-employment without social security (Mathauer et al. 2007; Xaba et al., 2002). In addition, it is very heterogeneous because it includes low, medium and some better high income groups. People in the informal sector are the self-employed who include vegetable vendors, hawkers, farmers, fishermen, pastoralists, semi-informal employees who are drivers and conductors of taxis, lorries, ‘matatus’, domestically employed employees (house helps and gardeners). Many people in this sector may not be organized in groups or associations based on their occupation, but gather in community-based
organizations (women’s groups, self-help groups, loan groups and religious associations) (Mathauer et al 2007).

The Oxford English dictionary defines health as “the state of being free from illness or injury”. The World Health Organisation (WHO) further improves on this definition. According to WHO, health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (WHO, 1978). WHO has further proclaimed that “the health of all the people is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states”, and that “the enjoyment of the highest attainable standards of health” is one of the fundamental rights of every human being. The Ottawa Charter for Health Promotion (1986) stated that health is “a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.”

Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing, and allied health professions. According to the World Health Organization, health care embraces all the goods and services designed to promote health, including “preventive, curative and palliative interventions, whether directed to individuals or to populations”. A country’s economic, social and political development is hinged on the good health of its population. Attainment of good health is vital in enhancing human development. A country with high-quality healthcare delivery system, good nutritional status, food security and absence of epidemic diseases will foster and spur all facets of development. Human health has a major role to play in economic development.
There is a direct link between the health of a population and its productivity, and this relationship has been demonstrated in industrial countries, which are now benefiting from years of investment in health services (Schultz, 1993).

Since independence in 1963, Kenya has continued to design and implement policies aimed at promoting access to modern healthcare in an attempt to attain its long-term objectives of health for all. Though the physical infrastructure for health in Kenya has expanded rapidly since independence, maintenance and upkeep of public sector health facilities has become an inseparable burden for the Ministry of Health recurrent budget (Kimalu, et al, 2004).

There are five ways of financing health care in Kenya. The first is by the government funding health care in Kenya via general taxation. The sick person will then receive free treatment or pay lower user fee. The second way of financing health care in Kenya is through Compulsory Social Health insurance. This is a government sponsored program funded via taxes where the benefits, eligibility requirements and other aspects of the program are defined by statute, and an explicit provision is made to account for the income and expenses (often through a trust fund). All formal employees are members to this insurance as in the case of National Hospital Insurance Fund.

The third method is through direct out-of-pocket payments or self-financing by citizens and households. Direct out of pockets payments is the most widely used financing method in Kenya. When an individual purchases prescription drugs over the counter or when one visits the hospital or clinic he or she pays the fees in cash. The fourth method of financing health care is through Private Health Insurance. This is a voluntary health insurance scheme that enables individuals to
contribute premiums regularly in exchange of medical cover in case the contributor gets sick. The fifth way of financing health care is through Community-based financing. The poor communities mobilize resources to secure financial protection against the cost of illness. This type of financing involves the communities in revenue collection, pooling, resource allocation, and service provision. It is non-profit oriented and targets people with unsteady income, mostly from the rural and urban poor. The arrangements in community-based financing schemes are diverse and differ from one community setting to the other.

There are many factors that influence the individual to choose a given type of health care financing model. Some of these factors include economic, social, health care packages or features, health care plan alternatives, spatial and environmental factors. These factors are the price, perceived value of health care, risk aversion, individuals’ income, education and employment. Unemployment and income are also a key determinant on the decision of health care financing method. Demand for health insurance increases as personal income increases. Cost of premium determines whether the person purchase it or not (Cramer & Jensen, 2006; Monheit et al 2004). Medical knowledge and standards of care have allowed people to live healthier, longer, and more productive lives. It has been established that financing models are key determinants of dictating the quality and the amount of health care received by an individual. Effects of choice of health care financing increase (depleting assets and savings) or decrease financial burden of the populations and promote or depreciate health care status (Owino and Were, 1998).
Adequate health care financing correlates with high quality health care services provided to a person and this determines performance of health system. Kenya was in position 140 out of 191 countries. This composite measure of overall health system attainment is based on a country’s goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index (World Health Organization; World Health Report, 2004).

The NHIF was established by an Act of parliament in 1966 as a department of the Ministry of Health, which oversaw its operations, but responsible to the government Treasury for fiscal matters. The original Act of Parliament that set up this Fund in 1966 has over the years been reviewed to accommodate the changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. The Fund was set up to provide for a national contributory hospital insurance scheme for all residents in Kenya. The Act establishing the NHIF provided for the enrolment of all Kenyans between the ages of 18 and 65 years and mandates employers to deduct premium from wages and salaries. The level of contribution is graduated according to income, ranging from KES 30 to KES 320 per month. Contributions and membership are compulsory for all salaried employees. NHIF’s vision is “To be a World Class Social Health Insurance Scheme”. Its mission is “To provide accessible, affordable, sustainable and quality Social Health Insurance through effective and efficient utilization of resources to the satisfaction of stakeholders” (MoH, 2004).

The NHIF draws its membership from people employed in the formal sector and from the informal sector or self-employed individuals. The Fund’s formal sector membership has increased over time from 40,000 civil servants in 1966, 1.1 million in 2000, rising to over 2.2
million currently. In 1998, when the Fund became a state corporation, informal sector membership was slightly over 21,000 and grew to about 48,000 in 2001. There was deliberate effort to bring these members on board in 2002 when the figure rose to over 100,000 members. Due to adverse selection, the registration campaign was stopped and registration was allowed to only those who visited NHIF offices. The second attempt was in 2005, which has resulted to the current growth trend (NHIF, 2009).

Currently, there are 2,501,502 members of NHIF and contributed KES 4,502,666,986 in the year 2007/2008. Government and donors are also contributory members whose total contribution to the funds was KES 300 million in the financial year 2007/2008. The members’, government’s and donor’s total contribution was KES 4.8 billion in the financial year 2007/2008. NHIF paid out a total of KES 2,022,200 to government, mission and private hospitals and health centres in the financial year 2007/2008 for the purpose of financing its members health care (NHIF, 2009).

1.2 Statement of the Problem

The Kenya National Bureau of Statistics estimates that fifty-six per cent of the Kenyan population are poor, living on one dollar or less a day per capita (CBS, 2005). The national health accounts in 2002 reported that more than a third of the poor who were ill did not seek care, compared with only 15% of the rich. Fifty-two per cent of poor households cited financial difficulties as the principal reason for not accessing health care (MoH, 2005b). Furthermore, 7.7% of poor households were faced with catastrophic health expenditure, i.e. out-of-pocket payments exceeding 40% of disposable household income (Xu et al., 2006). Expanding access to health care for the informal sector and the poor is therefore an important objective of the Kenyan health sector strategy (MoH, 2005b).
Household survey data show that the large majority of Kenyans (98% of the lowest, 96% of the 2nd and 95% of the 3rd quartile) have no health insurance, whereas 12% of the 4th and 25% of the highest quartile do have insurance (Xu et al., 2006). Private health insurance specifically is only accessible to the higher-income segment (Vinard and Basaza, 2006). Community-based health insurance (CBHI) was introduced in Kenya in 1999, and has not yet fully developed. Data from the Kenya Community-Based Health Financing Association show that about 32 schemes have been set up so far with 170,000 beneficiaries covered.

Why are five percent (5%) of the informal sector employees contributing to NHIF and not more? The proportion is too small, in the light of this, it can be deduced that there is something wrong somewhere. Kenya’s informal employees were 7.5 million in 2007 and 7.9 million in 2008 (Economic Survey 2009). However, there are only 381,272 (about 5% of the total average of the two years) contributors to the NHIF as at 30th June 2009 (NHIF 2009). What could be the reasons?

1.3 Objectives of the Study

The general objective of the study was to investigate the factors that influence choice of Health care financing by informal sector entrepreneurs at Nakuru Town.

1.3.1 Specific Objectives

i. To evaluate the effect of economic factors on the choice of health care financing by informal sector entrepreneurs.
To investigate the effect of customer-oriented design features on the choice of health care financing by informal sector entrepreneurs.

To assess the effect of social factors on the choice of health care financing by informal sector entrepreneurs.

To evaluate the effect of environmental factors on the choice of health care financing by informal sector entrepreneurs.

1.4 Research Questions

i. Do economic factors influence the choice of health care financing by informal sector entrepreneurs?

ii. What is effect of customer-oriented design features on the choice of health care financing by informal sector entrepreneurs?

iii. Do social factors affect the choice of health care financing by informal sector entrepreneurs?

iv. What is the effect of environmental factors on the choice of health care financing by informal sector entrepreneurs?

1.5 Significance of the study

The findings of the study will be important to employees because they will get to know the best ways of financing their health care without negatively affecting their economic and emotional status. From the study findings they will also be able to design the best financing model that will serve them as the informal sector population, without compromising on the quality of health care they received. The findings will also highlight the most important and key determinants that
influence individuals or group choice of health care financing and will be able to base their decisions on the findings.

To other scholars, the study shall be of great significance to them. Future scholars are going to have a base from which they are going to build their research on similar field of study. It will point out the gaps existing in as far as the same study is concerned and thus narrowing down for them the most important areas in which research should be carried out.

Trade unions and unionists are also going to benefit from this study. The unions shall get to know how important it is for their members who are drawn from the informal sector to acquire a health care financing scheme. It will be a wakeup call to the unions that health will be a wakeup call to the unions that health care financing is of the essence for their members. The study shall enable the unions and unionists to know how to go about advocating for better terms in as far as the existing health financing schemes are concerned.

To the National Hospital Insurance Fund and other health insurance providers, they shall get to establish the factors that affect the choice of health care financing by the informal sector employees given the fact that they have in the recent past tried to bring into the system the informal sector employees and success of the same is yet to be recorded. Therefore they will be made aware of the influencing factors when an informal sector employee is making a decision on health care financing. This will enable them come up with products or rather services that are tailored to suit the members of the informal sector employment.
1.6 Scope of the study
The study was centered on the factors influencing the Choice of Health Care Financing by Informal Sector entrepreneurs of Nakuru Town. The research took place as from July 2012 to November 2012. A population of 380 informal sector employees and owners of business enterprises were targeted by the study.

1.7 Limitations of the Study
This study faced several limitations. The study was exclusively limited to determining the factors influencing the choice of healthcare financing by informal sector employees. Yet a lot of formally employed workers do not have any other cover except the mandatory cover by the NHIF, which is many times insufficient to cover their health demands, especially for outpatient care. The study therefore omitted a large number of respondents who would have given better insight into the factors influencing choice of healthcare financing. The study limited itself to a small region in Nakuru Town, leaving out other regions in the town as well as the whole country.

In the process of carrying out the research, the researcher encountered other limitations which include: Data accessibility, accessing data both primary and secondary may prove to be a challenge for the research. The targeted respondents were not willing to disclose important information for the research as they considered most of the information to be very sensitive information and which should not be released. Uncertainty on what would become of them for disclosing the required information may be an issue. They feared being victimized by their seniors. To overcome this, the researcher sought the permission from the respective in charge of the various employees. Data from the respondents was insufficient to be used to answer the
research objectives sufficiently. This was the case because most respondents did not know much about the study topic. Limited resources on the part of the researcher were another limitation. The research lacked adequate funding for conducting the research. The researcher was forced to sample the targeted population in order to cover for the lack of finance.
CHAPTER TWO

2.0 Literature Review

This chapter gives a review of both empirical and theoretical literature. The conceptual framework and the research gaps are also given in this chapter.

2.1 Introduction

This chapter contains a review of literature. That is both theoretical and empirical literature review. It gives conceptual framework showing how the independent and dependent variables relate with each other. Finally it gives a gap to be filled by the study.

Promotion of the health status of all Kenyans is one of the most important objectives of the Government of Kenya. The government is therefore keen on making health services more effective, accessible and affordable. Health policy in this country therefore revolves around delivering basic quality health services, and how to finance and manage those services in a way that guarantees their availability, accessibility and affordability to those who need it the most.

The informal sector mostly consists of groups of people whose economic activities escape any socio-economic policy and regulation by the state. It has emerged in the urban and peri-urban centres as a result of the incapacity of the modern sector to absorb new entrants. The rationale of extending social security to the informal sector is informed by the benefits that an economy will derive from doing that. Extending cover to the informal sector helps an economy reduce poverty faster; it accelerates growth and promotes peace, stability and social cohesion. It is an indispensable part of the institutional tissue of an efficient market economy (Kayitare, 2009). Informal sector can be described as an enterprise employing less than 50 workers. This includes
home-based business, self employed, street traders and vendors, artisans, motor mechanics, iron-smiths, others are electricians, carpenters, tailors, wood and soft stone carving.

The informal sector continues to create jobs, develop skills and linkages to formal sector, create demand, supply, savings and investment; facilitate indigenous entrepreneurship and commitment to earn a descent living. The other emerging informal sector is bicycle and motor cycle transport especially in urban areas. Informal sector is predominantly an urban area activity concentrated in Nairobi, Rift Valley, Central and Nyanza provinces in that order. Many people in this sector may not be organized in groups or associations based on their occupation, but gather in community-based organizations (women’s groups, self-help groups, loan groups and religious associations) (Mathauer et al 2007).

Fifty-six per cent of the Kenyan population is poor by the World Bank definition, namely living on one dollar or less a day per capita (CBS, 2005). According to the national health accounts, more than a third of the poor who were ill did not seek care, compared with only 15% of the rich. Fifty-two per cent of poor households cited financial difficulties as the principal reason for not accessing health care (MOH, 2005).

2.1.1 Health Care Financing in Kenya

Since independence in 1963, Kenya has had a predominantly tax-funded health system, but gradually introduced a series of health financing policy changes. In 1989, user fees, or ‘cost-sharing’ were introduced. User fees were abolished for outpatient care in 1990, inspired by concerns about social justice, but re-introduced in 1992 because of budgetary constraints. Until recently, these fees have remained, with their impact on access to health care the subject of
several empirical studies. The user fee system was significantly altered in June 2004, when the Ministry of Health stipulated that health care at dispensary and health centre level is free for all citizens, except for a minimal registration fee in government health facilities. The most significant event since 1989 has been the government’s interest in social health insurance (SHI). The purpose of the latter is to ensure access to outpatient and inpatient health care for all Kenyans and to significantly reduce the out-of-pocket health care expenditure of households, especially the poorest. An intersectoral taskforce was established to prepare a national strategy and legislation as a first step in the preparation of Kenya’s National Social Health Insurance Fund (NSHIF). The implementation of a well-run and effective NSHIF will be a formidable challenge. The main objective is nothing less than granting all population groups, including the poor, access to a comprehensive benefit package of health services (Mwabu; Mwanzia and Liambila, 1995).

Kenya spent 5.1% of its Gross Domestic Product (GDP) on healthcare in 2002. This was well below the high-income OECD (Organization for Economic Cooperation and Development) countries’ average of 9.8% for the same period. Total health spending stands at about US$6.2 per capita, far short of the World Health Organization’s (WHO) recommended level of US$34 per capita. Life expectancy is also on the decline. In 2006, life expectancy for women was 51 years and 50 years for men. This is expected to decrease further due to the rising incidence and prevalence of HIV/AIDS. In 2006, the child mortality rate was 78 per 1,000 live births. Some 56% of the population lives in poverty. Worse still, this 56% contributed 51% of the total healthcare expenditure in 2002. The under-financing of the health sector has reduced its ability to ensure an adequate level of healthcare for the population. Thus, the provision of health and
medical care services in Kenya is partly dependent on donors. In 2002, more than 16% of the total expenditure on healthcare originated from donors. There are also other factors inhibiting Kenya’s ability to provide adequate healthcare for its citizens. These include: inefficient utilization of resources, the increasing burden of diseases and the rapid population growth. Access to health and medical care is unequally distributed across the country, as is the fertility rate and the level of education. Generally speaking, the Central Province and Nairobi are deemed to have the best facilities, whereas the North-Eastern Province is found to be the most underdeveloped (Kimani, Muthaka and Manda, 2004).

The Kenya health care system is made up of three official sub sectors namely public, voluntary (Non Governmental Organizations) and private. The public sector comprises the Ministry of Medical Services (MOMS), Ministry of Public Health & Sanitation (MOPHS), Ministry of Local Government (MLG), and health services of other ministries including the military and parastatals. The voluntary sub-sector consists of faith base organizations (FBOs) and no-governmental organizations (NGOs). The private sector includes the medical services provided directly by private health facilities and health professionals in private practices, also referred to as the private for profit sectors. There is also an unofficial sub sector comprising institutions and providers over which the MOMS and MOPHS (In this document, MOMS and MOPHS will be collectively referred to as The Ministry of Health, MOH) have no control, i.e. traditional medicine consisting of herbalists, bone setter spiritual healers and other practitioners. Kenya’s public health care system delivers the largest share of services. For outpatient services, government facilities account for 57 percent of total outpatient visits. About 15 percent of outpatients rely on chemists for care. Private and faith based health facilities account for 18 and 6
percent of visits respectively, while traditional healers attract only about 1 percent of patients. For inpatient services, government hospitals account for 59 percent of all admissions, with private and faith based health facilities each providing 14 percent of inpatient care (KDHS, 2007).

A variety of mechanisms are used to fund health services in Kenya, in line with the 1994 health policy framework. These include taxation through the MTEF budget, development partner funding, cost-sharing with users, both through insurance and user fees, and finally through NGOS. According to the Kenya National Health Accounts, (NHA, 2005/6) households’ accounted for 35.9% of total health spending representing a 13 % reduction from the 2001/2 accounts. Government accounted for 29.3 %. Donors and local foundations accounted for 31% and 0.1 % respectively. Donor contribution increased by 135% mainly as a result of an influx of funding from donors such as Global Fund for AIDS, TB and Malaria and the President’s Emergency Plan for AIDS Relief (PEPFAR). Private companies accounted for 3.3 %. A small proportion (0.4) of the health spending was unspecified (MOH,2004).

2.2 General Literature Review

2.2.1 Mechanisms of Health care financing in Kenya

Health care in Kenya is financed through 5 models as stated and explained below.

2.2.1.1 Model 1- Funding via general taxation

This model is characterized by the state collecting taxes, and a portion of it being allocated for the national health budget and used to finance public health programmes, curative services and personnel. Health services are either provided for free or for a minimum fee. In this model
Health Care cost is contained within the public health care delivery system. Sin taxes from tobacco and alcohol can be earmarked for health promotion (MOH, 2005).

There are drawbacks associated with this type of financing. First of all health competes with other critical priorities and social services such as education, and other concerns such as debt payment and the expenditure for the military and physical infrastructure. Taxes are hardly ever enough to provide the optimum level of Health Care required. Healthcare distribution is also not equitable due to absence of health care facilities and personnel in geographically isolated and economically depressed areas (MOH, 2005).

2.2.1.2 Model 2 - Direct out-of-pocket payments or self-financing by citizens and households
Out-of-pocket payments refer to direct outlays of cash by individuals to finance healthcare, which may or may not be later reimbursed. Common instances of out of pocket payments for health care when one purchases prescription drugs over the counter, or when one visits the hospital or clinic and pays the fees by cash. This model is characterized by free choice and free market of healthcare. It is the most inequitable means of financing health care. This is because providers have control over cost, type and quality of health care service. Health care cost is not contained, and health services are treated as commodities. With this type of financing more health resources/services and products are given to those who can pay more. Therefore, health resources are more likely found in areas (usually urban) where there are more people with higher income. Poor people, the elderly and those at risk do not to utilize privately owned facilities but overcrowd public health care facilities. These populations tend to have more serious illnesses by
the time they seek consultation, therefore needing more expensive treatment. Paying from out-of-pocket at the time when services are needed is catastrophic for people who have barely enough to feed their families (MOH, 2004).

2.2.1.3 Model 3- Private Health Insurance

The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long term nursing or custodial care needs. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Private health insurance is characterized by free choice and free market. Private health insurance companies control cost, type and quality of health care service. Such companies are profit-driven, and health services are treated as commodities. Consequently, health resources/services and products are given to those who can pay more. Like for out of pocket expenditure, health resources are most likely found in areas (usually urban) where there are more people with higher income. Those with irregular or no income such as the poor, unemployed, peasants, etc. are insufficiently or not covered at all by health care markets (MOH, 2005).

There are financial and non-financial variables that determine access to care with this type of financing. Financial variables include cost of insurance premiums, co-payments and the difficulty of receiving care due to a billing dispute. Non-financial variables include obtaining referrals, unapproved services, part-time employment and marital status, pre-existing medical conditions.
2.2.1.4 Model 4-Compulsory Social Health Insurance

Social insurance refers to a government sponsored program where the benefits, eligibility requirements and other aspects of the program are defined by statute, and an explicit provision is made to account for the income and expenses (often through a trust fund). Social insurance is funded by taxes or premiums paid by (or on behalf of) participants. Funds may also come from taxes levied from tobacco and alcohol, and compulsory insurance premiums from consumers. The program serves a defined population, and participation is either compulsory or the program is heavily subsidized that most eligible individuals choose to participate (MOH, 2004).

Through social insurance risks are transferred to and pooled by an organization, often governmental, that is legally required to provide certain benefits. Payments to hospitals or clinics can come in any form such as prospective budget, fee-for-service or charge per day/per admission/per diagnosis. Payment to physicians is by salary, capitation or fee-for-service. The economic burden of the health care system is collectively shared.

2.2.1.5 Model 5: Community-based financing

Having experienced health problems in catastrophic proportions, poor communities mobilized resources to secure financial protection against the cost of illness. This type of financing involves the communities in revenue collection, pooling, resource allocation, and service provision. It is non profit-oriented and targets people with unsteady income, mostly from the rural and urban poor. The arrangements in community-based financing schemes are diverse and differ from one community setting to the other (MOH, 2005).
The model has many unique features and is characterized by a high social acceptability among community members, and strong involvement and sense of ownership of the community. Its success depends on a number of factors including first, the willingness of low-income households to contribute (as long as they are assured of access to quality health care and the cost of health care is subsidized by government or donor funds). Through community based financing, people’s access to drugs, primary and hospital care is improved. Secondly, for a successful community based financing scheme, it should accommodate the irregular and often non-cash revenue of members. Thirdly, it depends on the availability of a functional and complementary health care delivery system from which to purchase services, medicines and medical supplies, trained and competent management, greater efficiency in collection, pooling, management and use of scarce health resources. Outside help to augment existing funds, such as from government subsidies and donation, is also needed (MOH, 2005).

2.2.2 Health Care Financing In Kenya

Kenya has also adopted the elements of primary healthcare all targeting priority causes of morbidity and mortality and received strong donor support in their implementation. However, recurrent expenditure allocations of the Ministry of Health remain skewed in favor of curative care, which accounts for about 70 percent of the total.

Promotion of the health status of all Kenyans is one of the most important objectives of the Government of Kenya. The government is therefore keen on making health services more effective, accessible and affordable. Health policy in this country therefore revolves around delivering basic quality health services, and how to finance and manage those services in a way that guarantees their availability, accessibility and affordability to those who need it the most.
According to the Kenya Human Development Report (1999), government financing of health expenditure is about 60 percent of what is required to provide minimum health services, therefore implying that healthcare delivery in Kenya is under-funded. This is accentuated by inefficiency of the system, including lack of cost-effectiveness in service delivery. According to Obonyo et al (1997) the government finances 50 percent, private payments (insurance and out of pockets) finances 42 percent and donors, NGOs, missions and other institutions finance 6 percent of recurrent healthcare costs. However, preliminary information from Kenya’s National Health Accounts shows that the financial contributions of households (out of pocket expenses) exceed those of the government.

The weaknesses in health care financing have greatly affected access by the poor to effective health interventions. Take immunization for instance. While immunization saves the lives of 3 million children a year, an equal number die each year for not having received the basic vaccines. This situation is going to worsen, according to the United Nations Children’s Fund. There is a growing shortage of vaccines worldwide due to lack of increased and long-term financing approaches to sustain vaccine production. This is serious enough to jeopardize immunization programmes both in developed and developing countries. (South Review, 2002)

Health services and programmes in Kenya are financed from three main sources: the government through the Exchequer both, directly to the Ministry of Health and indirectly to other sectors with health-related functions (National Council for Population and Development, Ministry of Water Development, Ministry of Home Affairs, National Heritage, Culture and Social Services); donors who fund Ministry of Health programmes; the private sector and NGOs. The Ministry of
Health has used several financing mechanisms to support the health sector, for example cost sharing, social insurance, taxation, harambee and direct community contributions.

The Ministry of Public Health and Ministry of Medical Services are the main coordinators of provision of health services in Kenyans through network of dispensaries, health centres, church missions, industrial health units, district, and provincial and national referral hospitals.

Healthcare is both a consumer good as well as an investment good. Provision of good health services satisfies one of the basic human needs and contributes significantly towards maintaining and enhancing the productive potential of the people. Improving health services reduces production losses caused by worker illness, permits the use of national resources that had been totally or nearly inaccessible because of disease, increases the enrolment of children in school, and increases learning ability.

In 2004/2005, Government attempted to redress the shortcomings in the financing of healthcare in the country through the enactment of the National Social Insurance Act and proposed repealing of the National Hospital Insurance Fund Act (1998). However, the proposal generated tremendous negative reaction from many interest groups. This led to shelving of the proposed Act and a return to the status quo.

2.2.3 National Hospital Insurance Fund

2.2.3.1 Background

The NHIF was established by an Act of parliament in 1966 as a department of the Ministry of Health, which oversaw its operations, but responsible to the government Treasury for fiscal matters. The original Act of Parliament that set up this Fund in 1966 has over the years been
reviewed to accommodate the changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. The Fund was set up to provide for a national contributory hospital insurance scheme for all residents in Kenya. The Act establishing the NHIF provided for the enrolment of all Kenyans between the ages of 18 and 65 years and mandates employers to deduct premium from wages and salaries. The level of contribution is graduated according to income, ranging from Kshs. 30 to Kshs. 320 per month. Contributions and membership are compulsory for all salaried employees. NHIF’s vision is “To be a World Class Social Health Insurance Scheme”. Its mission is “To provide accessible, affordable, sustainable and quality Social Health Insurance through effective and efficient utilization of resources to the satisfaction of stakeholders”

2.2.3.2 Membership

The NHIF draws its membership from people employed in the formal sector and from the informal sector or self-employed individuals. The Fund’s formal sector membership has increased over time from 40,000 civil servants in 1966, 1.1 million in 2000, rising to over 2.2 million currently. In 1998, when the Fund became a state corporation, informal sector membership was slightly over 21,000 and grew to about 48,000 in 2001. There was deliberate effort to bring these members on board in 2002 when the figure rose to over 100,000 members. Due to adverse selection, the registration campaign was stopped and registration was allowed to only those who visited NHIF offices. The second attempt was in 2005, which has resulted to the current growth trend.
Table 1.2 NHIF contributions per income group for the year 2007/8

<table>
<thead>
<tr>
<th>Income group</th>
<th>Number of contributors</th>
<th>Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5,000</td>
<td>90,699</td>
<td>83,980,301</td>
</tr>
<tr>
<td>6,000 – 7,999</td>
<td>215,211</td>
<td>309,903,264</td>
</tr>
<tr>
<td>8,000 – 14,999</td>
<td>436,868</td>
<td>917,423,430</td>
</tr>
<tr>
<td>15,000 – 19,000</td>
<td>434,055</td>
<td>1,166,738,496</td>
</tr>
<tr>
<td>20,000 – 24,999</td>
<td>340,827</td>
<td>916,143,782</td>
</tr>
<tr>
<td>&gt; 25,000</td>
<td>412,380</td>
<td>1,108,477,709</td>
</tr>
<tr>
<td>Total</td>
<td>1,930,040</td>
<td>4,502,666,986</td>
</tr>
</tbody>
</table>

(Source: National Hospital Insurance Fund (2009)

2.2.3.3 Revenue and Disbursements

In 2007/8, the Fund’s total revenue was Kshs 4.8 Billion; of which members’ contributions were Kshs 4.5 Billion and income from other sources accounted for Kshs 300 Million.

Table 1.3 NHIF Benefit Payout per category (Amounts in ‘000)

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<tbody>
<tr>
<td>Gov.</td>
<td>184.6</td>
<td>245.5</td>
<td>243</td>
<td>257.7</td>
<td>517</td>
<td>522.3</td>
<td>796.9</td>
</tr>
<tr>
<td></td>
<td>(32%)</td>
<td>(29.6%)</td>
<td>(34%)</td>
<td>(37.6%)</td>
<td>(46.7%)</td>
<td>(36.9%)</td>
<td>(39.4%)</td>
</tr>
<tr>
<td>Mission</td>
<td>153.3</td>
<td>218.2</td>
<td>180.1</td>
<td>157.7</td>
<td>213.2</td>
<td>333.8</td>
<td>483.1</td>
</tr>
<tr>
<td></td>
<td>(27%)</td>
<td>(26.3%)</td>
<td>(25.3%)</td>
<td>(23%)</td>
<td>(19.3%)</td>
<td>(23.6%)</td>
<td>(23.9%)</td>
</tr>
<tr>
<td>Priv</td>
<td>237.6</td>
<td>365.3</td>
<td>290.2</td>
<td>270.1</td>
<td>375.7</td>
<td>558.8</td>
<td>742.2</td>
</tr>
</tbody>
</table>

24
2.2.3.4 Benefits

According to Section 22 of the NHIF Act, benefits are defined as reimbursements to accredited hospitals of expenses incurred by the contributors or their declared dependants. The act also provides for both in-patient and out-patient medical cover. Benefits daily rebates have risen gradually over the years from Kshs 75 to the current level maximum of Kshs 2,400 per hospitalized day.

In terms of claims processing the average period it takes to process a claim is currently 14 days down from over 90 days in 2001/2. The benefit payout ratio has also improved from 14.2% in 2000/1 to 45% in 2007/8.

Table 1.1 Ministry of Health Expenditure as percentage of Government Expenditure and GDP

<table>
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</thead>
<tbody>
<tr>
<td>Amount</td>
<td>9.7</td>
<td>11.6</td>
<td>15.2</td>
<td>15.4</td>
<td>16.4</td>
<td>19.2</td>
<td>23.01</td>
<td>27.47</td>
<td>32.7</td>
<td>34</td>
</tr>
<tr>
<td>KES (billion)</td>
<td>9.7</td>
<td>11.6</td>
<td>15.2</td>
<td>15.4</td>
<td>16.4</td>
<td>19.2</td>
<td>23.01</td>
<td>27.47</td>
<td>32.7</td>
<td>34</td>
</tr>
<tr>
<td>% of</td>
<td>8.4</td>
<td>7.7</td>
<td>9.01</td>
<td>8.33</td>
<td>6.99</td>
<td>6.1</td>
<td>5.73</td>
<td>7.6</td>
<td>6.3</td>
<td>6.5</td>
</tr>
<tr>
<td>Govt expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>% of GDP per capita</td>
<td>1.3</td>
<td>1.4</td>
<td>1.65</td>
<td>1.49</td>
<td>1.51</td>
<td>1.55</td>
<td>1.5</td>
<td>1.5</td>
<td>1.54</td>
<td></td>
</tr>
<tr>
<td>Cost sharing (KES billion)</td>
<td>0.55</td>
<td>0.71</td>
<td>0.78</td>
<td>1.03</td>
<td>1.00</td>
<td>1.00</td>
<td>1.5</td>
<td>1.98</td>
<td>2.15</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Ministry of Health (2009))

### 2.3 Empirical Literature

#### 2.3.1 Health Financing and Politics

In the United States of America, the 2008 presidential election also had health as a priority issue in the campaigns. John McCain and Barack Obama offered two very different visions of the healthcare future. While neither moved to single payer systems that provide automatic universal coverage, Mr. McCain sought to convert existing group insurance into an individual market and on the other hand Mr. Obama proposed to convert the individual and small business market to a group market similar to that of large employers and public plans. His proposal maintains the tax subsidies for employer sponsored insurance.
Kimalu (2002) makes a comparison with the US where insurance cover is largely a private affair but social security Funds such as Medicare and Medicaid provide coverage for so called bad risk groups – old age and disability pensioners and the poor. In the US, those who are not covered by private insurance or who do not qualify for either Medicare or Medicaid remains without coverage. As of 1994, more than 43 million people or 16% of the population had no health insurance. In Germany, on the other hand, the health services are funded through compulsory contributions (normally referred to as sickness funds). Employers and employees make contributions to the health fund and are represented on the boards of the funds. Kimalu’s conclusion on user fees (which are the payments made by the patient out of his pocket) is that they have been found to reduce use of healthcare in countries like Ghana and Zaire. The most appropriate way would be to channel the out of pocket expenses by the household into a prepaid Fund.

According to Techlink International Report (1999), few firms provide healthcare insurance in the strict sense of insurance in private healthcare insurance in Kenya. The general insurance firms offering healthcare insurance as one of their portfolio of products include American Life Insurance Company (ALICO), Apollo Insurance, GMD Kenya, Kenya Alliance Insurance Company Ltd, and UAP Provincial Insurance. Other firms run medical schemes and they are in two categories: the first category provides healthcare through own clinics and hospitals (these include AAR Health Services, Avenue Healthcare Ltd, Comprehensive Medical Services, Health Plan Services), while the other category provides healthcare through third party facilities (examples are Bupa International, Health Management Services and Health First International). These medical schemes are also known as Health Management Organisations (HMOs).
Financing of health care was also an emotive political issue. In the run up to the 2007 Kenyan election, the main political parties made different pledges regarding health care of the country, that all pointed out the importance of health care to the people of Kenya. The Party of National Unity (PNU) stated in their manifesto “In order to realize our common vision, the PNU Government is committed to undertake that no Kenyan will die or suffer from lack of food and healthcare for reasons of poverty, and all Kenyans shall have access to affordable, food, transport and healthcare”. The key issues in the ODM manifesto were: free quality secondary education, enhanced security and free health care for children under 5 years.

The engine of this large “group market” is the organization of a national private insurance marketplace under the auspices of the federal government. The Insurance Exchange would mirror the federal employee-health-benefit-plan, which provides health insurance to all federal employees including members of Congress, the president, and the Supreme Court. As an alternative to the Insurance Exchange, people can choose to enter a public-plan similar to Medicare.

According to Obonyo et al (1997) the government finances 50 percent, private payments (insurance and out of pockets) finances 42 percent and donors, NGOs, missions and other institutions finance 6 percent of recurrent healthcare costs. However, preliminary information from Kenya’s National Health Accounts shows that the financial contributions of households (out of pocket expenses) exceed those of the government. The weaknesses in health care financing have greatly affected access by the poor to effective health interventions.
Health services and programmes in Kenya are financed from three main sources: the government through the Exchequer both, directly to the Ministry of Health and indirectly to other sectors with health-related functions (National Council for Population and Development, Ministry of Water Development, Ministry of Home Affairs, National Heritage, Culture and Social Services); donors who fund Ministry of Health programmes; the private sector and NGOs. The Ministry of Health has used several financing mechanisms to support the health sector, for example cost sharing, social insurance, taxation, harambee and direct community contributions. The Ministry of Public Health and Ministry of Medical Services are the main coordinators of provision of health services in Kenyans through network of dispensaries, health centres, church missions, industrial health units, district, provincial and national referral hospitals.

A cost sharing programme was mooted in the 1984/88 Development plan and its implementation started in December 1989 through a cabinet paper. The main objective of the policy was to encourage increased cost recovery from users of public health and to generate additional revenue. The rationale was to charge those who are most able to pay and channel the subsidies to those least able to pay (Owino et al, 1997b). Increasing poverty levels and concerns on quality and access necessitated a change of policy by the government in 2004 from cost sharing to the 10/20 policy where individuals were required to pay Kshs. 20 and 10 in health centers and dispensaries respectively.

The user fees introduced as a result of the cost-sharing programme led to a financial burden to the poor and other vulnerable groups, restricting their access to health care services due to their inability to pay. Therefore, on equity grounds, waivers and exemptions were introduced to
cushion the poor and other vulnerable groups against adverse effects of the user fees. Besides, granting of waivers to the poor and provision of exemptions by the Government, are considered to be part of crucial components in poverty reduction strategies (Owino and Were, 1998).

The National Hospital Insurance fund is also another avenue for financing health care in Kenya. The NHIF was established by an Act of parliament in 1966 as a department of the Ministry of Health, which oversaw its operations, but responsible to the government Treasury for fiscal matters. The original Act of Parliament that set up this Fund in 1966 has over the years been reviewed to accommodate the changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. The NHIF draws its membership from people employed in the formal sector and from the informal sector or self-employed individuals. According to Section 22 of the NHIF Act, benefits are defined as reimbursements to accredited hospitals of expenses incurred by the contributors or their declared dependants. The act also provides for both in-patient and out-patient medical cover. Benefits daily rebates have risen gradually over the years from Kshs 75 to the current level maximum of Kshs 2,400 per hospitalized day.

According to Kimalu (2002), the prospect of generating more resources through the NHIF is limited and uncertain due to weak administrative system, poor investment portfolio and low claims settlement. There is a need for an immediate review of NHIF’s financial and administrative structure in order to meet the challenge of providing social health insurance for all Kenyans. In 2004/2005, Government attempted to redress the shortcomings in the financing of healthcare in the country through the enactment of the National Social Insurance Act and proposed repealing of the National Hospital Insurance Fund Act (1998). However, the proposal
generated tremendous negative reaction from many interest groups. This led to shelving of the proposed Act and a return to the status quo.

Kimani et al (2004), contends that a health insurance fund is social (that is, it includes all members of society) when it subsidizes the poor, elderly and sick, as well as when it promotes equity and access to everyone at no profit. The core values in social health insurance embody a concern for the plight of the poor. In social insurance financing, health services are paid for through contributions to a health fund. The benefits for one individual are not usually directly related to the contributions he has made but rather they aim to redistribute income between different income groups.

Private health insurance also plays a critical role in the country’s health financing system. Self employed people may opt to take these private insurance instead of NHIF. Health insurance is considered private when the third party (insurer) is a profit organization (Republic of Kenya, 2003a). In private insurance, people pay premiums related to the expected cost of providing services to them. Wang’ombe et al (1994) identify two categories of private health insurance in Kenya: direct private health insurance and, employment-based insurance. Direct private health insurance is very expensive and only the middle and high-income groups afford it (Nderitu, 2002). In the employment-based plans, the employer provides care directly through employer-owned on site health facility, or through employer contracts with health facilities or healthcare organizations. These are both voluntary health schemes and are not legislated by the government.
The Association of Kenya Insurers (AKI) Annual report 2006, points out that in Kenya, there are currently 13 local underwriters in the Private sector health insurance market. Of these the top 3 underwriters (Jubilee, APA, CFC life) command 66% of the market share.

In the year 2006, the Association of Kenya Insurers (AKI) wrote Kshs 3.6 Billion premiums from a membership base of over 300,000 insured persons. In terms of claims analysis, the benefit payout ratio ranges between 51% and 94% during the same period, the market claims ratio was 81%, underwriting loss Kshs 144 Million due to operating expenses of 19% of Gross Written Premiums or 24% of Net Earned Premiums.

2.3.2 Factors influencing choice of Health Care Financing

The factors that influence a person’s choice of financing healthcare include the price, perceived value of health care, risk aversion, individuals’ income, education and employment. Unemployment has been cited as the biggest factor that influences the type of healthcare financing decisions. Income also plays a big determinant on the decision of health care financing method. Demand for health insurance increases has as personal income increases. Cost of premium determines whether the person purchase it or not (Cramer & Jensen, 2006; Monheit et al 2004).

The people in the informal sector usually have various factors that influence their decision on the choice of financing their own health care. The key determinants that have been identified as influencing people in the informal sector have been reflected as economic factors, availability of health care alternatives, customer-oriented design features, social factors, environmental factors and behavioral factors.
2.3.2.2 The Economic Factors

The economic factors include income, occupation and employment. Income is the amount of money a person receives as a reward for rendering services or goods. Income in turn influences individual purchasing power (Scotton 1969; Cameron, Trivedi et. al. 1988; Savage and Wright 1999). The people with higher income are likely to purchase health insurance as compared to those with lower income because they have higher disposable income and are able to pay for insurance premiums regularly (Xu et al., 2006; Dror, 2006). Those with lower income are more likely to pay out of their pockets because they will pay for health care services only when they are sick. Lack of money is indeed a major reason why many do not join health insurance. Due to less income, low-income households are reluctant to join insurance schemes because they do not readily like the idea of ‘paying’ for services they might not use (Brown and Churchill, 2000).

Occupation refers to the work a person does in order to earn income. White collar jobs and being in gainful employment are key economic determinants that influence the choice of financing health care because they reflect higher income. People with white collar jobs are likely to purchase health insurance as compared to those in blue collar jobs (Jutting, 2004; Savage and Wright 1999). In low-income countries, many people resort to out-of-pocket payment due to various factors. Poor households do not have steady sources of income to enable them to contribute insurance premiums. This is especially true for households in the rural areas and those employed in the informal sector. One of the key developmental aspects of financing health care systems is to get the money from various sources (Ching and Mcquire, 1997).
Knowledge and experience of full medical costs influences health care financing choice by an individual. If a person knows how and when health care costs become high, he or she is able compare various financing options. Incase a person is able to predict higher medical costs in future he or she may consider taking health insurance or enter into community based scheme but if he predicts lower costs, he may opt for direct out of pocket payments. Thus future expectations on treatment expenditure are critical for health insurance purchase decision (Mtei, & Jo-Ann Mulligan, J., 2007; Osei-Akoto, 2003; Kronick and Gilmer 1999).

2.3.2.4 Customer-Oriented Design Features as a Factor

Insurance scheme design features, particularly the benefit package, payment modes and the enrolment basis (as an individual or family), influence people’s decisions. For the Kenyan case, our hypothesis is that for many informal sector workers the relatively high amount of upfront payment and (previously) inflexible collection schedules constitute barriers to joining the NHIF (Carrin, 2003; Schneider, 2004). These studies suggest that customer satisfaction and attitudes are important factors affecting health care financing decision. In a study of the life insurance market, Durvasula, Lyonski et. al. (2004) found that customer satisfaction was positively associated with customer’s repurchase decisions. In the field of health insurance, this satisfaction may come from the experience and services provided by insurer and also policyholder’s interaction with provider of services may significantly influence his decision. Services offered such as recovery from sickness, a medical condition, or an accident.

The coefficient for the health status variable took a negative sign, implying that the demand for health insurance was likely to be low among individuals who were in excellent, very good or
good health. In the current study, 58.3% of the respondents in the sub-sample with a health insurance policy assessed their health status as either fair or poor. Persons or individuals expecting to be sick or who knows that they are sick are more likely to finance their health care through insurance. In addition, Knowledge about health insurance came out also as significant important factor affecting the decision (Jutting, J 2005; Goodman et al 2004).

2.3.2.5 Social Factors

The demographic factors include age and household size. According to economic theory predicts that individual who are advanced in age tend to increase investment in health. Increase in household size reduces that likely hood of purchasing health care insurance because increased household size reduces the per capita income (Mtei, & Jo-Ann Mulligan, J., 2007). The social factors include education and marital status. Individuals with high educational levels are two times more likely to purchase health insurance than those with lower educational level. They suggest that a better educated person is likely to be better informed about both the health services available in the system. This is because an educated person has positive relationship with earning and education and knowledge about making small insurance payments to avoid the risk of catastrophic medical expenditures.

Married people are more likely to have insurance cover than those who are single, separated or divorced. Married people tend to have high demand for insurance due to the need to protect their children, combined higher income, being averse to the risk of higher health expenditures as compared to those who are single, separated or divorced. This association has been based on the premise that families, which have higher hospitalization risk, will have higher probability of
purchasing health insurance. Age has also been found having positive and significant impact on the probability of having health insurance cover in many studies (Savage and Wright 1999).

2.3.2.6 Environmental Factors

Spatial and environmental factors include area of residence and environmental rating. Those living in formal settlement or rural white-owned farms are seven times more likely to purchase health insurance than those living in informal urban or rural settlements. This could be partly due to the reflection of their economic status. Those who felt that their environment was good was or excellent were twenty seven times likely to purchase health insurance than those who lived in fair or poor environments. This may have been due to the reflection that those living in affluent, formal had better economic status than those in informal settlements where they lacked some basic social amenities. (Kirigia, J. et al 2005)

2.3.2.7 Behavioral Factors

Behavioral factors include factors such as those who use contraceptive, use alcohol, and smoking. Those who use contraceptive were less likely to purchase health insurance than those who do not use them. This suggests that contraceptives are not necessarily linked with individual’s attitudes towards risk. Those who consumed alcohol were less likely to purchase health insurance than those who did not (Kirigia, J. et al 2005). Risk preference affects the choice of financing individuals’ health care. Most individuals in the informal sector are not risk averse. Due to unemployment, informal sector individuals would rather forgo health insurance and risked getting without access to medical care but save some cash from not paying the insurance premiums to buy basic commodities like food, pay rent and purchase cloths. Some believe that they are indigent and opt to remain uninsured (Nyman, J. 2003).
Community based financing health care scheme in Kenya is yet to be developed. There are about 32 schemes in Kenya with about 170,000 beneficiaries since its inception in 1999. Key factors that determine use of community based healthcare financing include individual willingness to join and contribute to the scheme (Xu et al., 2006; Dror, 2006). If people perceive that the organization is being managed transparently they are likely to join community based. The spirit of solidarity in Kenya is strong as indicated by the word ‘harambee’ which means ‘let’s pull together’. Through ‘harambee’ people share and support each other within their community. This spirit is conducive for community based health care financing (Brown and Churchill, 2000). Lack of credibility and trust in fund managers may negatively affect demand for health insurance and community based schemes (Schneider, 2004).

In Kenya, where corruption in public services and parastatals has been a huge problem, they have been often faced with negative attitudes. Parastatals such as NHIF may be having low rate of contributors because it could be suffering from negative public perceptions. The study carried out on beliefs and attitudes of Albanians towards informal payments revealed that consequences, social and control beliefs influenced the decisions of Albanians to make informal payments for their health care. The study further revealed that Albanians who had positive attitudes were likely to make informal payments as compared with those with negative attitudes (Vian, T & Burak, J. L 2006). Furthermore, the theory of planned behavior asserts that individual attitudes and beliefs about something play a major role in influencing behavior and intentions of persons to act (Ajzen, I. 2002b).
2.3.3 Factors Affecting Purchase of Health Insurance

The studies focusing on examining the factors affecting health insurance purchase decision have found that income is an important factor (Scotton 1969; Cameron, Trivedi et. al. 1988; Savage and Wright 1999). Healthcare expenditure is another important variable which affects health insurance purchase decision (Kronick and Gilmer 1999). This association has been based on the premise that families, which have higher hospitalization risk, will have higher probability of purchasing health insurance. Other factors such as age, education, gender etc. have also been found to be important factors affecting health insurance purchase decision.

The role of education in health decision-making has been well documented by Grossman (1972) and Muurinen (1982). They suggest that a better educated person is likely to be better informed about both the health services available in the system and the benefits of joining a private health insurance fund and at the same time he/she also likely to be healthier which would lower the probability of health risk. Age has also been found having positive and significant impact on the probability of having health insurance cover in many studies (Cameron, Trivedi et. al. 1988; Ngui, Burrows et. al. 1989; Savage and Wright 1999). Another important factor found is gender which also plays an important role in the insurance decision through its effect on expected medical consumption (Sindelar 1982).

Bhat and Jain (2006) analyses the factors that affect health insurance purchase decision in a micro health insurance setting. The study was based on a household survey in the Anand District of Gujarat in India. The research focused on analyzing two separate but inter-related decisions. The first decision that the household takes is whether to buy health insurance policy and if the
decision to purchase is positive, the next decision that follows is the extent (total coverage) of purchase. The study used Heckman two-stage method to analyse both these decisions by taking care of sample selection problem.

The study finds that income is an important factor. Another factor that came as significant was the health expenditure of the family. The study also used perception variables related to coverage of illnesses and health expenditure and these were found significant in insurance purchase decision. Knowledge about health insurance came out also as significant important factor affecting the decision. In the case of extent of purchase decision, the study finds that up to a certain level of income households do not allocate resources to insurance and therefore purchase less health insurance. After a certain level of income, increase in income will result in purchase of health insurance as people now can afford to buy health insurance and it will save them from potential risk. At higher levels of income household purchase of insurance decreases as households are willing to retain the risk.

The number of children in the household was also found as an important factor affecting the extent of health insurance purchase decision. Age also came as an important variable in deciding the extent of insurance and people in higher age groups relatively spend more on insurance. Two other variables, coverage of illnesses and health/illness expenditure are also significant. These two variables show that illnesses coverage perception and future expectation about the healthcare expenditure are important for the health insurance purchase decision and for the extent of health insurance purchase decision.
Other than the studies related to health insurance, the literature from marketing field on reasons for taking up health insurance provides some insights into this area. These studies have been done with different products providing evidence on reasons for intention of repeat purchase (Hocutt 1998; Storbacka et. al. 1994; Zahorik and Rust 1992). These studies suggest that customer satisfaction and attitudes are important factors affecting the decision. In the field of health insurance, this satisfaction may come from the experience and services provided by insurer and also the policyholder's interaction with provider of services may significantly influence his decision.

The literature addressing demand-side factors of health insurance in low-income countries is limited. Econometric studies look at socio-demographic and socio-economic household and individual determinants such as age, sex, income, education and their correlation with health insurance ownership. It is found that persons with higher income and higher education are more likely to have health insurance (Xu et al., 2006). Persons with at least a secondary level of education are also two times more likely to be in possession of a health insurance policy than those with a lower level of education. This could be attributed to a positive relationship between a person's educational level and propensity to acquire skills, stock of knowledge and his/her market and non-market productivity and earnings, and education and knowledge about the advantage of making regular small insurance payments to avoid the risk of catastrophic medical expenditures (Kirigia et al., 2005).
2.4 Gap to be filled by the study

The study sought to fill the gap regarding to the reasons influencing the choice of health care financing by informal sector entrepreneurs. Nothing can explain reasons why most informal workers in Kenya fail to contribute to their Health care financing other than their negatives attitude and beliefs towards their own health. Monthly premiums like those of NHIF at Kshs 160 per household are very low and the benefits to be derived from it in case of an illness are more ((NHIF, 2009). Other than NHIF there are several players offering health insurance cover for example AAR, Co-operative insurance company of Kenya (CIC insurance),and UAP provincial insurance company among others (wwwира.go.ke).
2.5 Conceptual Framework -

Independent Variables

- Economic factors
  - income earned,
  - occupation of individuals

- Customer-Oriented features
  - benefit package,
  - payment modes and enrolment basis

- Environmental Factors
  - residence and
  - environmental rating of individuals

- Behavioral Factors
  - use of contraceptives,
  - alcohol and smoking

- Social Factors
  - age of individuals,
  - household size and marital status

Dependent Variable

Choice of Health Care Financing

Source: Author (2012)
CHAPTER THREE

3.0 Research methodology

3.1 Introduction

This chapter focused on the procedures and methods that were used to select, study, collect, analyze and present the opinions, thoughts and feelings of informal sector operators on health care financing.

3.2 Research Design

This research was carried out by use of a descriptive survey. Survey is a research design used for obtaining description of a particular group of people (Forzano, 2008). Descriptive survey has the advantage of describing some phenomenon determining its basic dimension and allowed the researcher to define it and deduce how often it occurs.

3.3 Target Population

The study targeted all the 3800 informal sector entrepreneurs at Nakuru town (KNBS, 2012). Authenticity of these entrepreneurs was obtained from the municipality of Nakuru Town.

3.4 Sampling Technique and Sample Size

The sample of respondents was determined using Stratified Random sampling which rely on mere chance to determine who would be selected in the sample and called for random selection in the inclusion of the cases into the sample. A total of 380 respondents out of a target population of 3800 entrepreneurs targeted were picked randomly. This represents 10% of the total number of respondents’ targeted. 10% is a fair number and yielded fair results. This sample is recognized
as being representative of the entire population (Mugenda & Mugenda, 2003). This method allowed the researcher to use inferential statistics in the analysis and interpretation. The 10% sample is also better as it also takes into account natural bias and budgetary constraints (Kothari, 2006).

Table 3.1: Sample Size

<table>
<thead>
<tr>
<th>Clusters</th>
<th>Target Population</th>
<th>10% Random Sampling</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cloth traders</td>
<td>380</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Shoe traders</td>
<td>330</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Drivers</td>
<td>230</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Motor mechanics</td>
<td>270</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Iron-smiths</td>
<td>210</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Electricians</td>
<td>350</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Carpenters</td>
<td>250</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Tailors</td>
<td>350</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Soft stone carving</td>
<td>180</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Owners of eating joints</td>
<td>140</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Grocery shop owners</td>
<td>250</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Motor cyclist</td>
<td>380</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Vegetable vendors</td>
<td>300</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Property owners</td>
<td>180</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>3800</td>
<td>380</td>
<td>380</td>
</tr>
</tbody>
</table>

The above figure shows the cluster units and the number of informal sector operators that were chosen from each cluster, making up the 380 informal workers that were required for the sample size.
3.5 Data Collection Procedure

The study used primary data collection method via a questionnaire to collect data on factors influencing health care financing decisions by the informal sector operators. The researcher approached the respondents and requested them to participate in the survey. In addition, purpose of the study was explained to the participants who were assured of confidentiality. The questions were close ended but a space was provided at the end of the questions allowing the respondents to give other information they deem relevant for the study. Space provided below the questions allowed the respondents to answer in their own words and reveal more about their feelings and opinions towards their choice of health care financing.

3.6 Data analysis and interpretation

The data that was collected and recorded in tables to analyze the data; average scores for the responses per item was calculated with 5 strongly agree and 1 strongly disagree, and the yes or no answers were also tabulated. The data was then tabulated on frequency tables and analyzed using SPSS to compute averages, percentages and frequency tables. Content analysis was also used in analyzing qualitative information from responses that had been submitted by respondents.
CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.1 Introduction

This chapter presents the analysis and findings of the study. The main objective of the study was to investigate the factors that influence choice of Health care financing by informal sector entrepreneurs at Nakuru Town. Data was collected by way of a questionnaire. The data collected was in line with the objective of the study. The questionnaires were dropped and picked by the researcher of this study from entrepreneurs at Nakuru Town target population. A total of two hundred and ninety entrepreneurs responded to the questionnaire and returned. This was an adequate response rate and could therefore, be used as a basis for drawing conclusions. Also descriptive analysis was utilized where tables and percentages were used to summarize the data collected.

4.2 Response Rate

The findings indicate that two hundred and ninety entrepreneurs responded to the questionnaire. This represents 76% of the total sample size. Those who responded were from all the entrepreneurial clusters targeted for the study. In relation to the response rate majority of the respondents were from the cluster of cloth traders and motor cyclist representing 11% respectively. This was followed by those in the tailors cluster representing 10% of total respondents. The clusters with the least respondents was that of motor mechanics and that of
owners of eating joints representing 4% of the total respondents respectively. The table 4.1 below best illustrates these facts.

Table 4.1 Response rate

<table>
<thead>
<tr>
<th>Clusters</th>
<th>Sample Size</th>
<th>Frequency</th>
<th>%Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cloth traders</td>
<td>38</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>Shoe traders</td>
<td>33</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Drivers</td>
<td>23</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Motor mechanics</td>
<td>27</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Iron-smiths</td>
<td>21</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Electricians</td>
<td>35</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Carpenters</td>
<td>25</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Tailors</td>
<td>35</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Soft stone carving</td>
<td>18</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Owners of eating joints</td>
<td>14</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Grocery shop owners</td>
<td>25</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Motor cyclist</td>
<td>38</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>Vegetable vendors</td>
<td>30</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>Property owners</td>
<td>18</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>380</strong></td>
<td><strong>290</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Source: Author (2012)**

The study findings indicate that most respondents who were willing to respond to the questionnaire were from the clusters of cloth traders and motor cyclist. This can be deduced to mean their willingness to participate in understanding choices of health care financing that they are likely to choose from.
4.2.1 Age

The study sought to find out the age of the respondents. The findings indicate that majority of the respondents were in the age category of 18-27 years representing 35%. This was followed by the age category of between 27-38 years at 28% of the total response rate while in the age category of 38-47 years it was 23% representation. Figure 4.1 below best illustrates these facts.

Figure 4.1 Age

![Age](image)

Source: Author (2012)

The study findings indicate that more young people participated in the study more than the older people since they are see to care more about their future other than the older generations of people.

4.2.2 Level of Education

The study sought to find out the highest level of education of the respondents. The findings indicate that majority 104 of the respondents had high school level of education while 88 respondents have primary school education and below. On the other hand there were 62 and 26 respondents in the level of education of some college and bachelor's degree respectively. In the
master’s and above level of education there were 10 respondents. Figure 4.2 below illustrates these facts.

**Figure 4.2 Level of education**

![Level of education chart](chart.png)

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary school and below</td>
<td>88</td>
</tr>
<tr>
<td>High School</td>
<td>104</td>
</tr>
<tr>
<td>Some college</td>
<td>62</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>26</td>
</tr>
<tr>
<td>Master and above</td>
<td>10</td>
</tr>
</tbody>
</table>

*Source: Author (2012)*

The study findings indicate that majority of those who responded to the study did not have higher levels of education and there is likelihood that education influences the choice of healthcare financing.

### 4.2.3 Marital Status

The study sought to find out the marital status of the respondents. The findings indicate that 129 out of a total of 290 respondents were married as opposed to 80 who were still single. Equally 45 and 21 of the respondents were cohabiting and widowed respectively. Apart from the above 15 of the respondents were divorced. The figure 4.3 below best illustrates these facts.
4.3 Marital Status

The findings indicate that majority of the respondents were married and these can be assumed to mean that those who have families are more likely to participate in studies relating to the choice of health care financing for purposes of understanding more about what the best choices in market are to safeguard them from issues to do with health.

4.2.4 Household income in Kenya Shillings

The researcher was also interested in establishing household income of the respondents. The findings indicate that that majority of the respondents 119 had a current income of Kenya shillings 10,001-15,000. This was followed by those who had a household income of Kenya shillings 5001-10000. Apart from the above 34 respondents have a current household income of Kenya shillings 15,001-20,000. Those who have a current household income in Kenya shillings under 5,000 were 26 and lastly those who have 20,001 and above household income were 22.

Figure 4.4 below illustrates the facts.
The findings indicate that majority of the respondents have a current household income in Kenya shillings of 10,001-15,000. This amount is significantly a low figure as compared to the average income of most well earning individuals who are able to come up with different choices of health care financing.

4.2.5 Children under 18 living in the Household

The researcher also sought to find out how many children under 18 years old living in different households. The findings indicate that majority of the households 111 have children less than 18 years who are between 1-3 children. This was followed 103 respondents who have 4-6 children who are less than 18 years while 58 respondents stated that they had 7-9 children living in their household who were less than 18 years. On the other hand 12 respondents confirmed that they had 10 children and above whom were less than 18 years living in their households. Some
respondents 6 in number had no children in their households below 18 years. This is best illustrated in the figure 4.5 below.

Figure 4.5 Children under 18 living in the household

![Children under 18 living in the household](image)

Source: Author (2012)

From the study, findings indicate that majority of the respondents have 1-3 children below 18 years living in their households. There is a likelihood that financial obligation are too much for households to sustain that number of dependants owing to the fact that their current households income for most of the respondents are below Kenya shilling 20,000. This therefore influences the choice of health care financing that the respondents are likely to engage in.

4.2.6 Where Respondents Live

The study sought to find out where the respondents live. The findings indicate that majority of the respondents 91 live in Shabab area and environs followed by those living in Bangladesh and
environ at 77 respondents. These were followed by those living in Free Area and environ 63, 49 respondents were living in Langalanaga and environs while lastly the number of the respondents was living in Mlimani and environs. The figure 4.6 below best illustrates these facts.

**Figure 4.6 Where Respondents Live**

```
<table>
<thead>
<tr>
<th>Series 1</th>
<th>Shabab Area and Environ</th>
<th>Langalanaga and Environs</th>
<th>Free Area and Environs</th>
<th>Mlimani and Environs</th>
<th>Bangladesh and Environs</th>
</tr>
</thead>
<tbody>
<tr>
<td>91</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```

*Source: Author (2012)*

From the findings of the study it is clear that Shabab area and environs has the most respondents.

**4.3 Factors Influencing the Choice of Health Care Financing by Informal Entrepreneurs**

The study sought to establish the factors influencing the choice of health care financing by informal entrepreneurs. The following indicate the findings of the study.
4.3.1 Economic Factors

Table 4.2 The average cost of getting treatment

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kshs 0 – Kshs 4,000</td>
<td>146</td>
<td>50%</td>
</tr>
<tr>
<td>Kshs 4,001 – Kshs 8,000</td>
<td>83</td>
<td>29%</td>
</tr>
<tr>
<td>Kshs 8,001 – Kshs 12,000</td>
<td>42</td>
<td>14%</td>
</tr>
<tr>
<td>Kshs 12,001 – Kshs 16,000</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>Above Kshs 16,000</td>
<td>8</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Author (2012)

The researcher sought to find out how the respondents paid the cost of treating their ailments. The findings indicate that majority, 157 of the respondents paid their cost of treating the ailments from their pockets while 67 respondents have insurance. On the other hand 53 respondents paid their treating ailments from government sponsored programs. Apart from the above 10 respondents make no payment while 10 respondents make no payment.

From the study findings 83% of the respondents believe that economic factors influence the choice of health care financing. This was as opposed to 17% of the respondents who did not think that this was the case.

On the other hand the researcher sought to find out the economic factors the respondents thought influenced the choice of health care financing by informal entrepreneurs. The respondents stated that the economic factors include income, occupation, compensation, supply and demand and
employment. The findings indicated that people with higher income are likely to purchase health insurance as compared to those with lower income because they have higher disposable income and are able to pay for insurance premiums regularly.

The study sought to establish whether the respondents have any medical insurance. 23% of the respondents stated that they have medical insurance. While 77% of the respondents stated that they did not have any medical insurance.

On the other hand the study sought to find out from the respondents the average costs of getting treatment in case of an ailment. The findings indicate that majority 146 of the respondents spend an average of Kenya shillings 0-4,000 as the cost of getting treatment in cases of an ailment. This was followed by 83 respondents, those who spent an average cost of between Kenya shillings 4,001-8,000. On the other hand 42 respondents spent an average cost of between 8,001-12,000 Kenya shilling while 11 respondents spent an average of Kenya shillings 12,001-16,000. These facts can best be illustrated in the table 4.2 below.

4.3.2 Customer-Oriented Design Features

Table 4.3 below best illustrates the findings of the study in relation to customer-oriented design features.
Table 4.3 Extent to which Customer-oriented design features influence the choice of health care financing by informal sector entrepreneur

<table>
<thead>
<tr>
<th>Feature</th>
<th>1-No influence</th>
<th>2-Least extent</th>
<th>3-Great extent</th>
<th>4-Greater extent</th>
<th>4-Greatest extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit package</td>
<td>7</td>
<td>34</td>
<td>45</td>
<td>80</td>
<td>118</td>
</tr>
<tr>
<td>Payment modes</td>
<td>9</td>
<td>36</td>
<td>41</td>
<td>77</td>
<td>89</td>
</tr>
<tr>
<td>Enrolment basis</td>
<td>12</td>
<td>43</td>
<td>67</td>
<td>50</td>
<td>67</td>
</tr>
<tr>
<td>Inflexible collection</td>
<td>19</td>
<td>40</td>
<td>30</td>
<td>32</td>
<td>63</td>
</tr>
<tr>
<td>Schedules</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Response</td>
<td>12</td>
<td>38</td>
<td>46</td>
<td>60</td>
<td>84</td>
</tr>
</tbody>
</table>

Source: Author (2012)

The researcher also sought to find out whether customer-oriented design features influences the choice of health care financing. From the findings 63% of the respondents feel that customer-oriented design features influenced their choice of health care financing. This was as opposed to 37% of the respondents who feel that customer-oriented design features does not have an influence in their choice of health care financing. Equally, the findings sought to find what out what customer-oriented design features the respondents thought influenced the choice of health care financing by informal entrepreneurs. The respondents stated the following as the customer-oriented design features: benefit package, payment modes, enrolment basis and inflexible collection schedules.
In relation to the customer-oriented design features the researcher sought to establish the extent to which various customer-oriented design features influence the choice of health care financing. Using a scale 1-5 as shown below the findings indicate that majority 118 of the respondents felt that benefit package customer-oriented design feature influences the choice of health care financing to the greatest extent followed by 89 of the respondents who feel that payment modes influences the choice of health care financing. Apart from the above the respondents 67 and 63 respondents feel that enrollment basis and inflexible collection schedules respectively influences the choice of health care financing to the greatest extent. As expected by the research benefit package customer-oriented design feature influences the choice of health care financing by informal sector entrepreneurs as confirmed from the study findings.

4.3.3 Social Factors

The table 4.4 below best illustrates findings on social factors.

Table 4.4 Extent to which social factors influence the choice of health care financing by informal sector entrepreneurs

<table>
<thead>
<tr>
<th>Factor</th>
<th>No influence</th>
<th>Least extent</th>
<th>Great extent</th>
<th>Greater extent</th>
<th>Greatest extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>7</td>
<td>14</td>
<td>26</td>
<td>60</td>
<td>81</td>
</tr>
<tr>
<td>Household size</td>
<td>3</td>
<td>16</td>
<td>32</td>
<td>51</td>
<td>101</td>
</tr>
<tr>
<td>Marital status</td>
<td>3</td>
<td>17</td>
<td>15</td>
<td>49</td>
<td>89</td>
</tr>
<tr>
<td>Educational level</td>
<td>7</td>
<td>26</td>
<td>39</td>
<td>33</td>
<td>79</td>
</tr>
<tr>
<td>Average Response</td>
<td>5</td>
<td>18</td>
<td>28</td>
<td>48</td>
<td>88</td>
</tr>
</tbody>
</table>

Source: Author (2012)
The study sought to establish whether social factors influence the choice of health care financing. The findings indicate that 64% of the respondents feel that social factors influence their choice of health care financing as opposed to 36% who do not think social factors influence their choice of health care financing. The researcher also wanted to establish the social factors the respondents thought influences their choice of health care financing. The respondents stated the following as the social factors that influenced their choice of health care financing; marital status, educational level and household size. Others include: perceptions of benefits and dis-benefits, gender issues, religion, ethnicity, family, location and life partner and children.

Equally, the study sought to find out the extent to which various social factors influence the choice of health care financing. The findings indicate that household size had the greatest influence their choice of health care financing at 101 respondents followed by 89 respondents who stated that marital status had the greatest extent on the choice of health care financing.

4.3.4 Spatial and Environment Factors

The table 4.5 below best illustrates the findings on spatial and environment factors.

Table 4.5 Extent to which spatial and environmental factors influence the choice of health care financing

<table>
<thead>
<tr>
<th>Factor</th>
<th>No influence</th>
<th>Least extent</th>
<th>Great extent</th>
<th>Greater extent</th>
<th>Greatest extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of residence</td>
<td>6</td>
<td>29</td>
<td>23</td>
<td>79</td>
<td>54</td>
</tr>
<tr>
<td>Environmental</td>
<td>4</td>
<td>30</td>
<td>15</td>
<td>93</td>
<td>60</td>
</tr>
</tbody>
</table>
The study also sought to find out whether spatial and environmental factors influenced the choice of health care financing. The findings indicate that 63% of the respondents feel that spatial and environmental factors influence the choice of health care financing while 37% of the respondents do not feel that this was the case.

The researcher also wanted to establish the spatial and environmental factors that influence the choice of health care financing. The respondents stated the following as the spatial and environmental factors: the locations an individual lives in, the environmental rating, the surroundings of individuals and whether the location is for the rich or poor.

The study also sought to find out the extent to which spatial and environmental factors influence the choice of health care financing. The findings indicate that most respondents 93 in number feel that environmental rating as a spatial and environmental factor influences the choice of health care financing to the greater extent. This was followed by the rich or poor environment with 87 respondents with a greater extent while area of residence was supported by 79 respondents with an influence on the choice of health care financing at a greater extent.

4.3.5 Behavioural Factors

Table 4.6 below illustrates the findings on behavioural factors.

Table 4.6 Extent to which behavioural factors influence the choice of health care financing

<table>
<thead>
<tr>
<th></th>
<th>Rating</th>
<th>Average</th>
<th>Rich or poor Environment</th>
<th>Source: Author (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rich or poor Environment</td>
<td>3</td>
<td>4</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>27</td>
<td>87</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>87</td>
<td>18</td>
<td>59</td>
<td>58</td>
</tr>
<tr>
<td>Factor</td>
<td>No influence</td>
<td>Least extent</td>
<td>Great extent</td>
<td>Greater extent</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Use of Alcohol</td>
<td>15</td>
<td>56</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Smoking</td>
<td>17</td>
<td>50</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>Use of contraceptives</td>
<td>17</td>
<td>42</td>
<td>18</td>
<td>41</td>
</tr>
<tr>
<td>Negative Perceptions</td>
<td>10</td>
<td>21</td>
<td>18</td>
<td>56</td>
</tr>
<tr>
<td>Educational level</td>
<td>9</td>
<td>21</td>
<td>21</td>
<td>63</td>
</tr>
<tr>
<td>Average Response</td>
<td>14</td>
<td>38</td>
<td>22</td>
<td>40</td>
</tr>
</tbody>
</table>

Source: Author (2012)

The researcher also sought to establish whether behavioural factors influence the choice of health care financing. The findings indicate that 78% of the respondents feel that behavioural factors do influence the choice of health care financing. This was as opposed to 22% of the respondents who feel that behavioural factors do not influence the choice of health care financing. In relation to the behavioural factors that were thought to influence the choice of health care financing the respondents stated the following as the behavioural factors thought to influence the choice of health care financing: use of alcohol, smoking, use of contraceptives, negative perceptions and educational levels.
The study sought to find out the extent to which behavioural factors influence the choice of health care financing. The findings indicate that negative perceptions as a behavioural factor was seen by most respondents to influence the choice of health care financing to the greatest extent. This was followed by educational levels with 63 respondents who feel that it influenced the choice of health care financing to a greater extent.
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter deals with the summary, conclusions and recommendations of the study. It highlights the limitations as well as implications of the study for policy and practice.

5.2 Summary of Findings

The findings indicate that two hundred and ninety entrepreneurs responded to the questionnaire. This represents 76% of the total sample size. Majority of the respondents were from the cluster of cloth traders and motor cyclist representing 11% respectively. This was followed by those in the tailors cluster representing 10% of total respondents. The clusters with the least respondents was that of motor mechanics and that of owners of eating joints representing 4% of the total respondents respectively. The study findings indicate that more young people participated in the study more than the older people since they are see to care more about their future other than the older generations of people.

Majority of the respondents 119 had a current income of Kenya shillings 10,001-15,000. This was followed by those who had a household income of Kenya shillings 5001-10000. Apart from the above 34 respondents have a current household income of Kenya shillings 15,001-20,000. Those who have a current household income in Kenya shillings under 5,000 were 26 and lastly those who have 20,001 and above household income were 22. Majority of the households 111 have children less than 18 years who are between 1-3 children. This was followed 103
respondents who have 4-6 children who are less than 18 years while 58 respondents stated that they had 7-9 children living in their household who were less than 18 years.

On the other hand 12 respondents confirmed that they had 10 children and above whom were less than 18 years living in their households. Some respondents 6 in number had no children in their households below 18 years. The findings also indicate that majority of the respondents 91 live in Shabab area and environs followed by those living in Bangladesh and environs at 77 respondents. These were followed by those living in Free Area and environs 63, 49 respondents were living in Langalanaga and environs while lastly the number of the respondents was living in Mlimani and environs.

The study findings 83% of the respondents believe that economic factors influence the choice of health care financing. This was as opposed to 17% of the respondents who did not think that this was the case. The respondents stated that the economic factors include income, occupation, compensation, supply and demand and employment. The findings indicated that people with higher income are likely to purchase health insurance as compared to those with lower income because they have higher disposable income and are able to pay for insurance premiums regularly.

Majority 146 of the respondents spend an average of Kenya shillings 0-4,000 as the cost of getting treatment incases of an ailment. This was followed by 83 respondents, those who spent an average cost of between Kenya shillings 4,001-8,000. On the other hand 42 respondents spent an average cost of between 8,001-12,000 Kenya shilling while 11 respondents spent an average of Kenya shillings 12,001-16,000. From the findings 63% of the respondents feel that customer-
oriented design features influenced their choice of health care financing. This was as opposed to 37% of the respondents who feel that customer-oriented design features does not have an influence in their choice of health care financing. The respondents stated the following as the customer-oriented design features: benefit package, payment modes, enrolment basis and inflexible collection schedules.

The findings indicate that 64% of the respondents feel that social factors influence their choice of health care financing as opposed to 36% who do not think social factors influence their choice of health care financing. The following are some of the social factors that influenced their choice of health care financing: marital status, educational level and household size. Others include: perceptions of benefits and dis-benefits, gender issues, religion, ethnicity, family, location and life partner and children. 63% of the respondents feel that spatial and environmental factors influence the choice of health care financing while 37% of the respondents do not feel that this was the case. The spatial and environmental factors include: the locations an individual lives in, the environmental rating, the surroundings of individuals and whether the location is for the rich or poor.

In relation to the behavioural factors that were thought to influence the choice of health care financing the respondents stated the following as the behavioural factors thought to influence the choice of health care financing: use of alcohol, smoking, use of contraceptives, negative perceptions and educational levels.
5.3 Conclusion

In summary, the choice of health care financing is influenced by various factors but to different levels. Some of the factors that were thought to influence health care financing include: behavioural factors, economic factors, social factors, spatial and environmental and customer-oriented design features. It can also be concluded that there are other reasons why most informal workers in Kenya fail to contribute to their Health care financing including the price, perceived value of health care, risk aversion, individuals’ income, education and employment. Unemployment and income are also a key determinant on the decision of health care financing method. Demand for health insurance increases as personal income increases.

Adequate health care financing correlates with high quality health care services provided to a person and this determines performance of health system. The weaknesses in health care financing have greatly affected access by the poor to effective health interventions it is thus necessary for the government to ensure that there is adequate health care financing to all Kenyans.

5.4 Recommendations

Since the Ministry of Public Health and Ministry of Medical Services are the main coordinators of provision of health services in Kenyans through network of dispensaries, health centres, church missions, industrial health units, district, and provincial and national referral hospitals they should be at the forefront in enlightening entrepreneurs on the benefits of having a choice on health financing and how they can join health care financing programs.
The government through various departments must be made aware that healthcare is both a consumer good as well as an investment good. They should therefore ensure provision of good health services since this satisfies one of the basic human needs and contributes significantly towards maintaining and enhancing the productive potential of the people. Improving health services reduces production losses caused by worker illness, permits the use of national resources that had been totally or nearly inaccessible because of disease, increases the enrolment of children in school, and increases learning ability.

5.5 Suggestions for Further Research

Due to lack of enough time and resources, it is therefore recommended that further research be undertaken on the following areas;

(i) The influence of the economy of a country on the choice of health care financing case of the Kenyan government.

(ii) The impact of the corruption on the choice of health care financing among the entrepreneurs.

(iii) To establish whether extending health cover to the informal sector can help an economy reduce poverty faster, accelerate growth and promote peace, stability and social cohesion.
REFERENCES


My name is Maubi Collins Ongeri and I am undertaking a Master of Business Administration degree Program at the Kenyatta University majoring in Finance. One of my academic outputs before graduation is a thesis and for this I have chosen the research topic “Factors influencing the choice of healthcare financing by informal sector entrepreneurs”

The attached questionnaire will provide me with invaluable data for the thesis. I would be most grateful if you would complete it and submit to the researcher in a week’s time. To enhance confidentiality, I will request you not to write down your name in this tool.

Maubi Collins Ongeri
MBA Student,
Kenyatta University
APPENDIX II: QUESTIONNAIRE

Section A: Demographic

1.0 What is your age?
   - 18-27
   - 28-37
   - 38-47
   - 48-57
   - 58 and above

2.0 What is your highest level of education?
   - Primary school and below
   - High school
   - Some college
   - Bachelor’s degree
   - Master and above

3.0 What is your marital status?
   - Single
   - Married
   - Widowed
   - Divorced
   - Cohabiting

4.0 What is your current household income in Kenya shillings?
   - Under 5,000
   - 5001-10000
   - 10001-15000
   - 15001-20000
   - 20001 and above
5.0 How many children under 18 years old live in your household?

- None
- 1-3
- 4-6
- 7-9
- 10 and above

6.0 Where do you live?
- Shabab Area and environs
- Langalanga and Environs
- Free Area and environs
- Mlimani and environs
- Bangladesh and environs

Specify ____________________

SECTION B: FACTORS INFLUENCING THE CHOICE OF HEALTH CARE FINANCING BY INFORMAL ENTREPRENEURS

1. Economic Factors
a) Do economic factors influence your choice of health care financing? Yes ( )
No ( )

b) What economic factors do you think influence the choice of health care financing by informal entrepreneurs?

i) .................................................................
ii) .................................................................
iii) .................................................................

72
iv) .................................................................
v) others (Specify) ..............................................

c) Do you have medical insurance? Yes ( )

No ( )

d) Incase of an ailment what is the average cost of getting treatment?

<table>
<thead>
<tr>
<th>Please Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kshs 0 – Kshs 4,000</td>
</tr>
<tr>
<td>Kshs 4,001 – Kshs 8,000</td>
</tr>
<tr>
<td>Kshs 8,001 – Kshs 12,000</td>
</tr>
<tr>
<td>Kshs 12,001 – Kshs 16,000</td>
</tr>
<tr>
<td>Above Kshs 16,000</td>
</tr>
</tbody>
</table>

e) How do you pay for the cost of treating the ailments?

i) I make no payment ( )

ii) Out of my pocket ( )

iii) Government sponsored ( )

iv) Call for a harambee ( )

v) I have insurance ( )

f) What do you think are the economic factors that influence your choice of health care financing?

i) .................................................................

ii) .................................................................

iii) .................................................................

iv) .................................................................

v) Others (Specify) ..................................................
2. Customer-Oriented Design features

a) Does customer-oriented design features influence your choice of health care financing?
   Yes ( )
   No ( )

b) What customer-oriented design features do you think influence the choice of health care financing by informal entrepreneurs?
   i) .................................................................
   ii) ................................................................
   iii) .................................................................
   iv) ................................................................
   v) others (Specify ) .........................................

c) Indicate the extent to which the following customer-oriented design features influence the choice of health care financing by informal sector entrepreneurs. Use the scale 1-5 as shown below and tick the correct extent.

<table>
<thead>
<tr>
<th>Feature</th>
<th>No influence</th>
<th>Least extent</th>
<th>Great extent</th>
<th>Greater extent</th>
<th>Greatest extent</th>
</tr>
</thead>
</table>

1  2  3  4  5
3. Social Factors

a) Do social factors influence your choice of health care financing?

Yes ( )

No ( )

b) What social factors do you think influence the choice of health care financing by informal entrepreneurs?

i) ..............................................................

ii) ..............................................................

iii) ..............................................................

iv) ..............................................................

v) others (Specify ) ..........................................

c) Indicate the extent to which the following social factors influence the choice of health care financing by informal sector entrepreneurs. Use the scale 1-5 as shown below and tick the correct extent.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Least</td>
<td>great</td>
<td>greater</td>
<td>greatest</td>
</tr>
<tr>
<td>Influence extent</td>
<td>extent</td>
<td>extent</td>
<td>extent</td>
<td>extent</td>
</tr>
</tbody>
</table>
4. Spatial and Environment Factors

a) Does spatial and environmental factors influence your choice of health care financing?
   Yes ( )
   No ( )

b) What spatial and environment factors do you think influence the choice of health care financing by informal entrepreneurs?
   i) .................................................................
   ii) .................................................................
   iii) .................................................................
   iv) .................................................................
   v) others (Specify) .............................................

c) Indicate the extent to which the following spatial and environmental factors influence the choice of health care financing by informal sector entrepreneurs. Use the scale 1-5 as shown below and tick the correct extent.

<table>
<thead>
<tr>
<th>Factor</th>
<th>No influence</th>
<th>Least extent</th>
<th>Great extent</th>
<th>Greater extent</th>
<th>Greatest extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household size</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Behavioral Factors

a) Do behavioral factors influence your choice of health care financing?

Yes ( )

No ( )

b) What behavioral factors do you think influence the choice of health care financing by informal entrepreneurs?

i) .......................................................... 

ii) ..........................................................

iii) ..........................................................

iv) ..........................................................

v) others (Specify) ...........................................

c) Indicate the extent to which the following behavioral factors influence the choice of health care financing by informal sector entrepreneurs. Use the scale 1-5 as shown below and tick the correct extent.

<table>
<thead>
<tr>
<th>Factor</th>
<th>No influence</th>
<th>Least extent</th>
<th>Great extent</th>
<th>Greater extent</th>
<th>Greatest extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rich or poor Environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor</td>
<td>No influence</td>
<td>Least extent</td>
<td>Great extent</td>
<td>Greater extent</td>
<td>Greatest extent</td>
</tr>
<tr>
<td>------------------------</td>
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<td>--------------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Use of Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of contraceptives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Perceptions</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

End

Thanks for responding to the Questions.