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INVESTIGATION INTO FACTORS AFFECTING FINANCING OF PUBLIC HEALTH SERVICE PROVISION IN KENYA

By

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*Investigation into
factors affecting*



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DECLARATION

I declare that this is my original work and has not been presented for a degree in any other University

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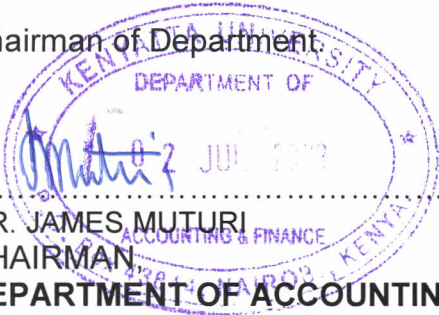
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ABSTRACT

This research report presented the findings of a study of factors affecting financing of Public health service provision in Kenya, examining challenges faced by the Ministry of Health in the Financing of public health service provision, the research will also seek to establish whether inequity in budget allocation affect financing of health care provision. The Government of Kenya over the years has managed to allocate only about five to seven percent of the national budget to the financing of medical care. This has resulted to major under funding of medical services provision in Kenya. Financing of public health service provision in Kenya has been a major problem which has prompted the government to shift from old method of financing health services through general taxation to a new system of user charges in public health facilities. The research project was carried out in Nairobi Province, health care providers, Ministry of Health and Ministry of Finance staff were interviewed. The objectives of the research was to investigate factors that affect financing of public health services in Kenya, the challenges faced by the Ministry of Health in Financing Public Health care provision were also examined, the study also established whether inequity in resource allocation to the Ministry of Health affects the financing of health care provision in Kenya.

In addressing the research objectives in the study the necessary data was collected using, a structured questionnaires and face to face discussions, after the preparation of these instruments, they were pre-tested by the researcher, later refined, before their use in the actual survey, for the questionnaires a drop and pick later method was used. The key respondents included staff of the Ministry of Health finance division, Ministry of finance Budgetary Division and the health care providers such as nurses, clinical officers, Doctors and administrators at the Kenyatta National Hospital. The results obtained from the questionnaires were analysis was on the percentage basis by use of management software statistical package for social scientists (SPSS).

The findings indicated that there are a number of factors affecting financing of public health service provision in Kenya, these include corruption, inadequate financing, mismanagement in the public sector, poor planning, inadequate budget allocation and so on. Results from the Ministry of Health and Ministry of finance revealed that there are major challenges faced by the both the Ministries in financing of public health services provision such as political interference, corruption in drug distribution, defaulters of cost sharing payments, corruption in the Ministry of health and inadequate budget allocation to the public health service.

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DEDICATION

This research project is dedicated to my late father Anton Wachiaji Oloo and my late grandfather Titus Abila Owano for believing in me at an early age, prophesying blessings upon my life, their unlimited guidance, support and encouragement which enabled me to pursue my education with determination to fulfill their dreams, though they have rested but their prophesy on my life is being fulfilled. May God rest their souls in eternal peace.

ABBREVIATIONS

NHIF	-	National Hospital Insurance Fund
NSHIF	-	National Social Hospital Insurance Fund
AKI	-	Associate of Kenya Insurers
NSSF	-	National Social Security Fund
HFS	-	Health Financing and Sustainability Project
WHO	-	World Health Organization
NGO	-	Non-Governmental Organization
STD	-	Sexually Transmitted Diseases
SHI	-	Social Health Insurance
CBS	-	Central Bureau of Statistics
HFS	-	Health Financing and Sustainability
AR	-	Applied Research
SAR	-	Small Applied Research
SBP	-	Standard Benefit Package

OPERATIONAL DEFINITION OF TERMS

Catastrophic Illnesses

Severe illnesses requiring prolonged hospitalization or recovery, usually involves high costs for hospitals and doctors and medicines. It refers to impairment of normal physiological function affecting part or all of an organism.

General Hospitals

Hospitals not specializing in any particular disease or age or sex. Hospitals dealing with cases of all kinds.

Cost-Effectiveness

Assessing relation of cost an operation to value of resulting benefits, effective in relation to its cost, it is usually calculated as basic cost plus profit factor.

Decentralization

To do away with centralization, distribution of administrative powers to local centers.

Socio-Economic Factors

In this study these will be defined as those socio-logical and economical aspects attributed to man and his environment such as education, health care, income and so on.

Demographic Factors

This will include factors such as age, employment, knowledge of health insurance cover, use of the insurance cover and knowledge of inadequate financing of the health care services

Health Care Providers

Health care providers are people who provides health care to a person or persons as a profession. Health care provides includes Physicians, Nurses, Physician Assistants, Nurse practitioners working in health institutions such as hospitals, nursing homes, clinics, dispensaries and so on.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Over the past decades, the Government of Kenya managed to allocate only about five to seven percent of the national budget to the financing of medical care. This has resulted in a major under funding of this essential service. From the time of independence in 1950s and 1960s up to the mid-1980s, government health services in sub-saharan Africa were provided free of charge, or at a nominal fee. However, in countries with significant private healthcare sectors, patients paid for services. Starting in the mid-1980s, African governments began to charge for publicly provided health services under the structural adjustment program sponsored by the Bretton Woods institutions. By the mid-1990s, over 30 countries in sub-Saharan Africa had implemented user fees in public health facilities. The fees were intended to increase service quality and coverage by raising money to buy drugs, to rehabilitate treatment rooms and medical instruments and to improve general management of health facilities. In most countries, the fee-income as a percentage of non-staff costs of healthcare averaged around 10-30%.

With the implementation of fees in public health facilities, payment for healthcare at government health facilities through insurance became important. This was particularly the case for inpatient care in government hospitals where treatment fees had been increased substantially. Prior to the fees, free public financing of hospital care was like an insurance cover for all. After the fees, exemption schemes were the safety nets for the poor. However, there were problems with fees exemption schemes because criteria for forgiving fees were not clear-cut or enforceable, and as a result, the poor did not generally benefit from these schemes (Collins et al., 2000).

In response to a persistent financial crisis in the health sector, the Kenya Government gradually shifted from the old method of financing health services through general taxation to a new system of user charges in public health facilities. Implementation of the new system started in 1988 and was concluded during the first quarter of 1993. Under the new system, health insurance has assumed prominence as a possible mechanism for cushioning households against risk of financial ruin in the event of catastrophic illnesses or inability to afford medical care. This study will examine the potential for developing private and public health insurance schemes in Kenya. The research will also examine the common insurance schemes purchased by the employers and to establish whether they are usually satisfied with these schemes. Policies to enhance efficient financing of health care provision will also be examined.

In addition to the financial difficulty, there are also severe allocative inefficiencies and other types of resource mismanagement. In the government sector for example, scarce public money has repeatedly been spent on ineffective interventions. In virtually all-African countries, there have been an over emphasis of clinical medicine at the expense of preventive medicine. Confounding these allocative and operational inefficiencies are ineffective administrative and bureaucratic practices. Money is, for example, routinely wasted on brand-name pharmaceutical instead of generic drugs; health workers are wrongly deployed and supervised; there are poor drug prescriptions; and much of the health infrastructure is underutilized. A separate but equally difficult problem is the glaring inequality in the consumption and distribution of health services in much of Africa. The urban poor and rural populations, for instance, have little access to basic health care, and receive low quality care. The bulk of available public financial resources is spent in secondary and tertiary health care facilities, which by design are urban-based and not easily accessible to the majority of the population.

Government financing of health care delivery in Kenya is inadequate, and there are no prospects for improving it in the short run (World Bank, 2001 and 2003). In the face of increasing demand of publicly provided health care, Kenya, like most other African countries, has over the last decade allocated only between five to seven percent of the national budget to the financing of health care. This has resulted in a major under funding of this essential service. Available evidence, especially in Kenya, shows that quality of care has declined over the years; general accessibility of health services has sharply decline, problem of shortages of drugs and medical commodities has become perennial, and facilities of the national referral hospital are in very poor condition (Republic of Kenya, 2000; Makinen, 2001). These problems have raised the urgency to search for additional financing strategies to supplement public resources in the health sector.

Research carried out in Kibwezi in rural Kenya examined the possibility of financing health services provision through user charges, the researchers have looked into three dimensions of health care financing. The first is cost-effectiveness; to select those interventions which improve health at least cost, or which maximizes health gain for a given budget. The study have however failed to examine the factors that affect the financing health service provision in Kenya. Karanga et al., (1995) in "Impact of user charges on vulnerable groups: the case of Kibwezi in Rural Kenya"

1.2 Statement of the Problem

Financing of public health service provision has increasingly become an important area of concern for many developing countries which are currently having rapid population growth rates and stagnating or declining economies (Bloom and Segall (2003) This is because public provision of health services is considered to be a right of citizenship which should not depend

on individual income or wealth, and emphasis is placed on reducing health inequalities. (Burnum et al. (2003)

The problem of financing public health service provision is of special interest to Kenya because apart from the inadequate budget allocations to health services, large population of Kenyan people lives below the poverty line where access to good health care provision at an affordable cost is very vital. According to Abel-Smith (2004) there is need to check the possibility of boosting resource allocation to health sector to enhance the provision of public health services.

This study therefore, addressed factors that affect financing of public health services provision in Kenya.

1.3 Objectives of the Study

1.3.1 General Objectives

The purpose of this research was to examine those factors that affect the financing of public health service provision in Kenya.

1.3.2 Specific Objectives

The following objectives were used in this study

1. To identify the factors influencing financing of public health provision in Kenya.
2. To determine the challenges faced by the Ministry of Health in financing public health service provision.
3. To establish whether inequity in budget allocation to the Ministry of Health affect financing of health care provision.

1.4 Research Questions

The following research questions were answered in this study:

1. What are the factors influencing financing of public health service provision in Kenya
2. What are the challenges faced by the Ministry of Health in financing public health service provision
3. Does inequity in budget allocation affect financing of public health service provision.

1.5 Justification of the Study

Kenya's current population policy aims at increasing budgetary allocation to Ministry of health to help in financing public health service provision (Republic of Kenya, 2004). One of the strategies of achieving this aim is through Budget allocation and strengthening of National Hospital Insurance Fund to enhance adequate financing of the health sector.

Kenya's current level of development indicates a need to set up and manage financing of public health care service provision so as to ameliorate the social, economic and medical problems that are faced by the citizens of Kenya as a result of lack of adequate resources to finance health care services. Increasing budgetary allocation will also reduce the social and economic consequences that are faced by the families and the patients and the society at large.

The starting point towards managing public health provision services is establishing insurance scheme which will boost financing of these services, with adequate funding equity provision of health care services will be realized. This is done in this study by investigating the factors that affect financing of public health service provision in Kenya.

1.6 The Scope and Limitation of the Study

The study focused on factors that affect financing of public health care services in Kenya. This area was chosen because of the constant financial constraints in the health sector in order to provide recommendations in a prioritized manner on ways to overcome the constraints. Research will be carried at the Ministry of Health Headquarters and Ministry of Finance.

In carrying out the study those working at the Ministry of Health Finance Division and the Ministry of Finance Budget Division were chosen because the researcher felt that they were likely to give more accurate information on their view on the on the factors that affect the financing of public health service provision in Kenya. Those who work in other departments were excluded from the study.

The study focused on Ministry of Health Headquarters and Ministry of Finance Headquarters in Nairobi, because all the resource allocations are monitored from the headquarters. The problem of the financing of public health service provision is also more understood in the headquarters than service districts.

The study has not been exhaustive in answering all the research questions raised in the study, this was due to resource limitation and because it was not possible to conduct an exhaustive field survey this was due to the fact that some respondents were not willing to answer some of the research question because of the nature of their job description. Some of the documents needed by the researcher were also classified and confidential therefore, getting details from such was not possible, this resulted to the researcher not get some of the vital information needed for this research. Limitation of resources were controlled by sending some of the forms through the internet which does not require traveling. Getting access to vital information needed

for the research was made possible through the departmental heads who assisted the research to get the necessary information needed for the research.

The other limitation faced by the researcher was that some of the respondents failed to return their form nor even bother to fill them, this in a way almost caused the paucity of data, this problems was handled by distributing extra questionnaires to obtain the required sample population.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Research findings shows that public health systems provide low coverage of those in greatest need, particularly the rural poor. This is assumed to be inefficient because it is argued that some of the most cost effective measures (for example immunization, ante-natal and post-natal care, treatment of common infectious diseases) are those which improve the health of those with the worst health status, namely the poor. (Republic of Uganda (2000). National Health Personnel Study. Ministry of Health, Kampala, World Bank (2001b). Better Health in Africa. Africa Technical Department, the World Bank). These studies report that, public health provision is of paramount important to the citizens of a country.

Another argument asserts that services provision is biased to hospitals. For example, hospitals may absorb 50 – 60% of current government health sector, 60-80% of government health facility expenditure, and around 70% of district expenditure (Mills 1990). Within hospital expenditure, the lion's share is often absorbed by central and general hospitals, leaving district hospitals with the smallest share. Tollman Schopper and Torres (2000). Health maintenance organizations in Development, Trisholini MGG et al (2002) methods of cost analysis, cost recovery and cost control for a public hospital in a developing country). However three qualifications must be made; it is difficult to set a norm for the share of health expenditure that should pass through hospital; hospitals often provide substantial primary care to local, densely populated urban areas (and there is scanty but mixed evidence on whether this is more expensive than if this care were provided by community-based facilities; the findings shows that much of the care provided by central and general hospitals is in fact what World Bank defines as 'essential

clinical care' that in many of these hospitals are misnamed. The facility is operating on the production possibility frontier.

When evaluating the proposed NSHF, information from Kenyan government policy discussion papers can be assessed, notably the "Sessional Paper on National Social Health Insurance in Kenya" (Republic of Kenya, 2004a) and the National Social Health Insurance Fund Bill (Republic of Kenya, 2004b). These will be referred to as the "Sessional Paper" and the "Bill" respectively. To help monitor implementing social health insurance (Carrin and James, 2005). The Performance of a social health insurance *(SHI) scheme, or indeed any type of health financing system, can be evaluated in terms of achieving universal coverage; securing access to appropriate health care for all at an affordable cost. Indeed, the World Health Organization (WHO) stated earlier that "the purpose of health financing is to make funding available, as well as to set a right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care" (WHO, 2000: 95). Hence we evaluate how well the NSHIF is expected to perform in its initial year of implementation in relation to the following health financing targets; Resource generation (sufficient and sustainable) Optimal resource use Financial accessibility of health services for all.

Assessing performance in these health financing targets is done by analyzing performance in the three broad functions of health financing – revenue collection, pooling and purchasing (WHO, 2000; Kutzin, 2001), where for each function key performance issues and associated indicators are specified. Revenue collection can be defined as the process by which the health system receives money from households, enterprises, government and other organizations including donors (WHO, 2000: 95).

Since independence in 1963, Kenya had a predominantly tax-funded health system, but then gradually introduced a series of health financing policy changes. User charges had been in place as well but were later removed, inspired by concerns about social justice. However, user charges for health services were introduced more formally in 1989. To day these user fees still exist and their impact on health care access has been the subject of several empirical studies. A National Hospital Insurance Fund (NHIF) was also introduced in 1965, but this was only compulsory for the formal sector workers and has been associated with an inadequate insurance benefit package. However, in November 2004, a new health financing reform was submitted to parliament, involving the establishment of National Social Health Insurance Fund (NSHIF) with the intent to cover all of the Kenyan population.

A study carried out in Kibwezi (Dahlgren, 2001) focusing on the use of health services revealed that outpatient care increased again after the lifting of the registration fee. Karanga et al 2000, carried out a study in Kisumu and Embu districts also revealed that outpatient attendance at government health facilities has dropped by about 50% during the initial cost-sharing period of 1989; attendance rose again by about 41% subsequent to the suspension of the outpatient registration fees (Mwabu et al, 2003). Research on the impact of user fees on attendance at a referral centre for sexually transmitted diseases (STD) confirm the empirical findings above; at Nairobi's Special Treatment Clinic for STD, attendance by men dropped by 40% during the user-fee period and rose again when fees were suspended, although only to 64% of the attendance level in the period before the introduction of user charges (Moses et al, 2002), Waiver and exemption mechanisms have also not been particularly effective (Bitran and Giedion, 2003).

However, the most significant event since the introduction of user fee policies in 1989 has been the government's interest in social health insurance as a health financing method and its possible implementation in Kenya. The purpose of such a system is to ensure access to outpatient and inpatient health care among all Kenyans and to significantly reduce the out-of-pocket health care expenditure of households, especially of the poorest (Nile, 2004). Already in May 2002, an inter-sectoral Task Force was established to prepare a national Social Health Insurance Fund (NSHIF) (Republic of Kenya 2003; Mboya et al, 2004).

The existing studies has not considered the efficiency that of achieving the desirable overall level of output of the health sector. In the World Bank Report of 1993 indicated that the mix of interventions financed and provided by the public sector is highly inefficient. This argument is a particular feature of the 1993 World Development Report (World Bank 1993a), and draws on a large study of the cost-effectiveness against the major diseases in developing countries which has produced 'league tables' which rank interventions and programmes in terms of cost per day (Jamison et al 2000), the results of the ranking, when compared with the 'global burden of disease indicate the extent to which it is possible to reduce the disease burden by devoting increased resources to the most cost-effective measures. For example, the World Development Report argues that implementing a basic public health package of interventions and package of essential clinical services would eliminate 32% of the daily losses in low income countries, and 15% in middle income countries (assuming 100% coverage).

In the World Bank Report (2003a), World Development Report 2003. Investing in Health, World Bank, Washington DC. In the report about ten developing countries were studied and the information was that there is a considerable scope for challenging the details of the calculations, it is difficult to quarrel with the basic conclusions of misallocated resources; indeed this point

has been made frequently in the past and was a prime reason for the primary health care emphasis of internal health policy in the 1980s and 1990s.

Gilson L. (2000) found out that publicly-provided services are highly inefficient (in terms both of technical and operating efficiency) in their use of inputs. Rigorous proof of this is difficult to supply since work has only begun on estimating production and cost functions for health facilities and as in developed countries studies, it is difficult to account for quality and case-mix variations in the estimates (Barnum and Kutzin 2003). A recent study by Wouters, however, was able to assess both technical and economic efficiency in a sample of health facilities in Nigeria (Wouters 2003). She concluded that many public (and also private) facilities were not operating at full technical capacity, and that public facilities were not using cost-minimizing combinations of health workers. Cost accounting studies commonly show wide variation in the unit costs of similar types of facility, providing evidence that strongly suggests inefficiency (for example Berman 2003; Bloom and Segall 1993; Gilson 2002; Koita et al 1999; Mills 2001; Purohit and Rai 2002).

World Bank study 2003 further gives evidence from input-specific studies. Two inputs cause particular concern, staff numbers and use, and drugs. Studies often show extremely low productivity of staff in the public sector (World Bank 2003b; Berman 2003; Lewis, Sulvetta and La Forgia 2001), together with a gross lack of the complementary resources that would enable them to practice.

A study in Uganda indicated that health personnel could be reduced by 30% without affecting the quantity or quality of services (Republic of Uganda 2001). The work of the Drug Action Programme in World Health Organization (WHO) has documented the efficiency of many public drugs supply and distribution systems (Foster 2003). Waste occurs through buying

unnecessarily costly drugs in inefficient ways; through distribution systems which favour hospitals, neglect peripheral services and lead to leakages; through poor prescribing of the wrong drugs, in wrong dosages and in excessive numbers; and in poor patient compliance.

Studies that have investigated the efficiency of public service provision especially on health insurance are beginning to show widespread problems, at least in the poorest countries, in the quality of care provided. For example, a study of dispensary care in a region in Tanzania showed that many facilities fell below the standard that might reasonably be expected in the circumstances of low-income countries, in terms both of structural quality (availability of necessary inputs and process quality (standards of patients care such as history taking and drug prescribing) (Gilson 2002).

A study in Papua New Guinea indicates – Thomason and Edwards 2001). There is thus ample evidence of the inadequate financing of public health services, in terms of all three types, of publicly-provided health services. Nonetheless, the evidence is by no means conclusive. In the first place, the evidence relies on what is still a relatively small number of country-specific studies, and the evidence of greatest inefficiency comes from the poorest countries in Africa, making it difficult to know to what extent the conclusions can be generalized. In the second place, there are also examples of highly efficient public health centers and district hospitals' (World Bank 1993a); in the Bank quotes the examples of Chile, China, Sri Lanka and Zimbabwe. In the third place, conclusive evidence is lacking, at least in the poorest countries, that non-public services necessarily perform and better than government dispensaries, and for certain services (for example ante-natal care) tended to perform worse (Gilson 2002).

2.2 Observed Inadequacies

Research findings have revealed that in terms of non cost-effective allocation of Resources, there are four main explanations commonly offered:

The dominance of the medical profession in health decision-making in most countries, and the incentive structures and status concerns that favour hospital practice and medical specialization. These priorities tend to be reflected in consumer preferences, though in addition poor, remote populations lack the political voice to bring their needs to the notice of the government.

The difficulty that all governments face in making policies on the basis of technical analysis; the policy-making process is often weak, and most ministries of health lack information on both costs and effectiveness.

Donor interventions have not in the past necessarily promoted a cost-effective mix of interventions. For example, a good part of the hospital infrastructure in the poorest countries has been financed by donors, with some investments taking place even quite recently.

It has also been argued that public choice theory explains much of the misallocation; the more influential consumer and producer groups are able to divert resources to the costly overprovision of services that predominantly benefit upper-income groups and have a much lower social rate of return, at the expense of providing basic services to the poor (Birdsall and James 1993). However, in the poorer countries such overprovision is relative; even hospitals lack adequate revenue to function properly.

Barnum and Kutzin (2003), Maynard and Postnett (eds) discovered that in terms of low technical and operating efficiency, many of the explanations lie in the nature of public bureaucracies and the lack of incentives they provide for efficient resource use. Decision-making is usually highly centralized, and planning and management structures weak. Government regulations impede action to improve efficiency (for example adjust staff numbers to local workloads), and the Ministry of Health, even if it wishes to, has very limited ability to introduce greater flexibility on its own authority. The health management cadre is dominated by medically-trained staff, who have little management training and are supported by relatively poorly educated administrators. Other explanations lie in the pervasive influence of lack of resources. Where government salaries suffice or only part of the month, as in some of the poorest African countries, it is not surprising that staff are poorly motivated, public resources get diverted to private use and utilization levels are low.

Other findings have also revealed that many government procedures which are conserved to be inefficient and irrational, such as withholding budgets at the start of the year and issuing supplementary budgets through the year, can be shown to be highly rational given the financial uncertainties facing governments (Caiden and Wildavsky 2000). The poorest countries are also dependent on donor funds; and financing has suffered from donor preferences for highly visible, 'vertical' programmes which have done little to help build capacity (World Bank 2003b; Save the Children Fund 2003). Some of the reasons for technical and operating inefficiency are well documented in the detailed studies of hospital costs in developing countries. (Trisolini et al 2002) demonstrates for the main hospital in St Lucia that only 20% of costs were within the control of the hospital, and there was no control over staff costs. There were no responsibility centers within the hospital, and hence few means to either find out about or control resource use. Similar deficiencies are found in public hospitals in many other countries (Mills 2003; Lewis et al 2001; Barnum and Kutzin 2003).

2.3 Bureaucratic Approaches and Evidence of their Success

In the recent studies of developing countries' health policies (World Bank 1993a and 1993b), it is remarkable how many reforms are proposed, but how little detailed evidence can be put forward on the impact of past reforms in terms of quantitative measures of financing and equity. Similarly, the book by Barnim and Kutzin (2003) documents very fully low levels of hospital financing, but its suggestions on remedies lack any actual evidence of the success of reform strategies. The policy process and management system improvements with a focus on whether they have creamed, or are likely to create, improvements in financing and cost-savings.

Studies have shown that a number of structural changes have been proposed to improve financing, the most common being decentralization of planning and management, usually to the 'district' level (Mills et al 2000). Some measure of decentralization is likely to be a pre-requisite for improved financing since it is the first step in informing local managers of the resource consequences of their actions, and in giving them some ability and incentive to improve their performance. However, despite fairly substantial experience of the implementation of decentralization policies, it is still not clear precisely what actions and conditions are necessary for decentralization to be a success (Mogedal forthcoming). Nor is it clear that structural change will necessarily result in changes in the way that organizations behave. Governments are often reluctant to hand over sufficient responsibility, particularly budgetary authority. Control staff is also often retained at the national level. Decentralization can blur line of authority, for example when district managers have responsibility both to a local chief officer and to the national Ministry of Health. Further, decentralization requires investment in the strengthening of local management levels and improvement of information systems. Whether this, plus the transactions costs involved in maintaining the new management structures, are outweighed by financial gains is not a question that appears yet to have been addressed.

Other findings have revealed that some structural changes proposed include reorganization of Ministries of Health in order to separate management of the health service from the running of the Ministry of Health; giving a greater degree of autonomy to large public hospitals; and setting up management boards for health facilities and districts. There has been little reported experience of the success of these strategies. The other strategy currently in fashion has a way of forcing some of the most inefficient parts of the health system, large tertiary hospital, to improve their performance. It is reported that this change in Tunisia has led to some gains in finance (World Bank 2003a). Similar reforms in several African countries (for example Kenya, Uganda, Zambia and South Africa) are as yet at a rather early stage to be evaluated. Again, as with general decentralization policies, there is no evidence on whether implementation costs would outweigh savings.

Researchers have suggested a much more radical way of enforcing cost savings is essentially to divest the public sector of the tertiary facilities, either by giving them independent status within the public sector and requiring them to raise their own income, or by shifting them into the private sector. For this approach to succeed subsidized treatment would need to be denied to patients with low priority conditions who would before have got free or subsidized care. A number of implications follow, the health system would become increasingly inequitable, since those with insurance or who could afford to pay the fees would still have access. It is also highly likely that those with political influence would continue to have access. Whether equity is improved in other ways would depend on the government's ability to shift at least some of the cost-savings to improve public health and essential clinical services in areas poorly provided for.

World Bank Report (2003) found out that tertiary hospitals are often the only hospital for large urban populations. Either patients have to be given access selectively (which would require establishing those procedures to which they are entitled, and corresponding subsidies,

information systems, and monitoring), or new, lower level facilities would have to be constructed. The scope for cost savings from reducing public expenditure on tertiary care would seem to be considerable, given its relatively high share of total public expenditure even if it is assumed that as much as half of current tertiary expenditure is for care which is known to be cost-effective (for example outpatient care; standard acute surgery)' the sums that might be saved or not negligible. There is little evidence that governments are likely to be able substantially to shift the costs of access to tertiary care to users in countries where only a small proportion of the population is insured. Denying access is politically difficult (especially since these facilities are often in the capital city) and considerable subsidies are likely to remain. Other studies have shown concern that if the management of such facilities is handed over to independent boards or to the private sector, they may pay higher salaries and/or take the facility up-market, raising the costs above their previous level. Hence the cost of care for publicly-subsidized patients may actually increase, though the quality may be better.

In Uruguay, for example, social insurance funding has been used to establish high technology institutes in the private sector (Marquez 2000). In Malaysia, the specialist Ministry of Health cardiology facility has been made autonomous and is required to raise its own revenue; those who are referred there and cannot pay must seek a government subsidy and join a waiting list for admission. The world Development Report states that Tertiary hospitals also may consume 30-50% of the health budget (World Bank 2003a). In a number of Latin American countries, cost savings have been sought by amalgamating the separate health services of the Ministry of Health and Social Security Funds, in order to reduce duplication Marquez (2000) comments that substantial savings and expansion of coverage have resulted. Such reforms reflect the emphasis placed until recently on rationalization, integration and coordination. Such values are being challenged by pro-competition policies.

(Vogel 2000) found out that recommendations are increasingly being made for Ministries for Health to make greater use of non-government organizations (NGOs) to deliver services for low income groups through subsidies. For example, mission health services have been advocated as models of quality of care and cost recovery for government facilities and as providing the advantage of overseas income (World Bank 2003b). The advantages of the non-for-profit sector more generally have also been emphasized (Fiedler 1990). In financial terms, the value of expanded use of NGO providers depends on two conditions: that they provide services of a given quality at lower cost (net of user fees) than the government, and/or that they are able to subsidize that cost from local or overseas charitable income. Despite the above assertions, there is little hard evidence of consistently better cost performance by missions than government (Bennett 2001), though their fee collection performance is probably better.

2.4 Social and Economic Changes

(Gilson 1987; Mcpake 1993) in their studies discovered that while the desirability of user fees as a means of shaping consumer behaviour is much debated, there is less controversy over the value of providing a facility with additional revenue. As long as the local level is permitted to retain all or most of the income. In Brazil, Nacaragua and Panama cost of collecting the fees is not out of proportion to the income raised, fee revenue can enhance technical efficiency by financing complementary inputs such as drugs and maintenance, and providing a supplement to staff salaries (Marquez 2000; Barum and Kutzin 2003). Improved quality should then reduce welfare losses from the imposition of fees, produce higher utilization levels and thus make better use of existing capacity. For example, in a study of hospital fees in the Dominican Republic, user fees income was argued to be important in enhancing effectiveness, productivity and staff morale (Lewis 2003).

The experience of the Bamako Initiative has demonstrated that by charging modest fees it is possible to support primary health services in a number of countries and improve their quality (McPake and Hanson 2003). Fees can also be used to encourage users to attend the local facility by exempting fees at higher levels for referred patients, or by fees graduated by level of facility (Abel-Smith and Creese 2000). There is little evidence of how well such 'bypass' fees work in practice and some evidence of problems; fees at the hospital level may not be high enough to discourage excessive use; or even, as in some Bamako Initiative countries, fees may be charged at the primary level but not further up the system.

2.5 Improvement in the Policy Process

In Kenya the main current improvement policy proposal was made in 2003, World Development Report, to make policy-makers aware of the burden of disease, the relative cost-effectiveness of means of reducing it and the need to define packages of essential interventions which are publicly-financed. While the analysis was initially in global terms, country-specific studies are now being carried out, for example in Uganda, Mexico, Thailand and Kenya. There are two main reasons for doubting that this strategy on its own (without structural changes) will have a major impact on efficiency. Firstly, cost-effectiveness analysis represents merely a means of improving the information available to policy-makers. It is likely to be only one factor that they will take into account in setting policies. While there is discussion on how to translate the results of the analysis into health care provision and provider behaviour, no firm recommendations on how to do this have yet emerged. Indeed, it is not nearly as simple as current analysis suggest. For the Authors accept that the Initiative has not solved the problem of financial access for the poorest.

According to the World Bank Report (2003) those strategies currently being suggested are improving the training of health workers, controlling the purchase of technology, designing reimbursement policies, and educating consumers. For many clinical interventions cost-effectiveness may vary enormously depending on the characteristics of the patient; a procedure may be cost-effective for a healthy adult in middle age, but not for an elderly person with multiple pathologies. Secondly, data on the cost-effectiveness of different interventions are largely unavailable for any specific country. Heavy reliance will thus have to be placed on general international experience and studies from a wide variety of countries. Cost-effectiveness analysis will lead to improvements in financing if the public sector provides more intervention of high cost-effectiveness to more people and fewer interventions of low cost-effectiveness. Whether it leads to cost-savings will depend on where the cut-off point is located.

2.6 Management System Improvement

Most of the measures to improve the financing of publicly provided health care fall under the general heading of Management System Improvements. They include improving planning and budgeting systems at all levels; improving information systems including information on costs; improved financial management and accounting systems; improved management in inputs such as staff, essential drugs and other supplies, transport, and buildings and equipment; controls on the supply of expensive technology including highly trained staff; creation and expansion of management cadres for hospitals and health authorities; management training for all health professionals involved in management; and quality assurance programmes. There has been much emphasis over a number of years on improving planning procedures, including building up planning units in ministries of health and introducing programmes budgeting; however, there is little evidence that they have had much influence on resource allocation except at managers of the development programme (Kalumba and Freud 2000; Issaka-Tinorgah and Waddington 2003)

According to Comper (2001), he argued that the earlier findings by Kalumba and Freud (2000) were largely confined to writing plans, which have had little impact on actual decisions. There is often a considerable gap between stated policies, for example commitment to primary and preventive care, and actual resources allocation patterns (Gilson 1999; Bloom and Segall 2001). One of the few evaluations of planning reforms, in the Ministry of Health in Ghana, suggests that the reforms were far too ambitious, introducing too much change at once, placing too many demands on untrained staff, and assuming that forward planning was of value when in reality staff worked in a highly uncertain financial environment, where even approved budgets were not honoured ((Issaka-Tinorgah and Waddington 2003).

Research studies available suggested that reforms should rather have been more modest, acknowledging political and economic realities and recognizing the need for training. Staffing inefficiencies can be approached in three ways; control of the numbers and mix of staff employed; and improved control of staff including providing incentives for improved performance and increasing ability to fire access or incompetent workers. Although many countries already, or soon will, have an oversupply of physicians (Abel-Smith 1999), there seems to have been little success in controlling numbers trained, at least in Latin America (Marquez 2000). Given the scope in the health sector for supply-induced demand, and the difficulty of changing expectations about public sector employment, the problem of excess supply may well persist.

In Dominican Republic (Lewis et al 1991), only 12% of contracted physician time could be accounted for by patient care activities, indicating serious underutilization of available manpower and misallocation of resources (79% of the hospital's budget was allocated to personnel). Hospital directors had virtually no control over staff assigned to the hospital. The solutions were seen to be greater autonomy for hospital managers and physician employment

and payment methods in the context of over-supply is suggested by the experience of Prosalud in Bolivia (Fielder 2000; Gish 2001; Fielder 2001).

Research findings ascertain that the problem of over-supply of doctors contributes to an inappropriate staff mix, especially in countries where female labour force participation (and hence the number of nurses) is low. Many countries in Africa and Kenya in particular have shown that it is possible to provide services of adequate quality with paramedical staff; however, where doctors are in excess supply there is considerable opposition to such substitution. Again, increasing local management authority to hire and fire and give incentives for good performance seems to offer the greatest potential for improving financing (and would require the implementation of decentralization policies).

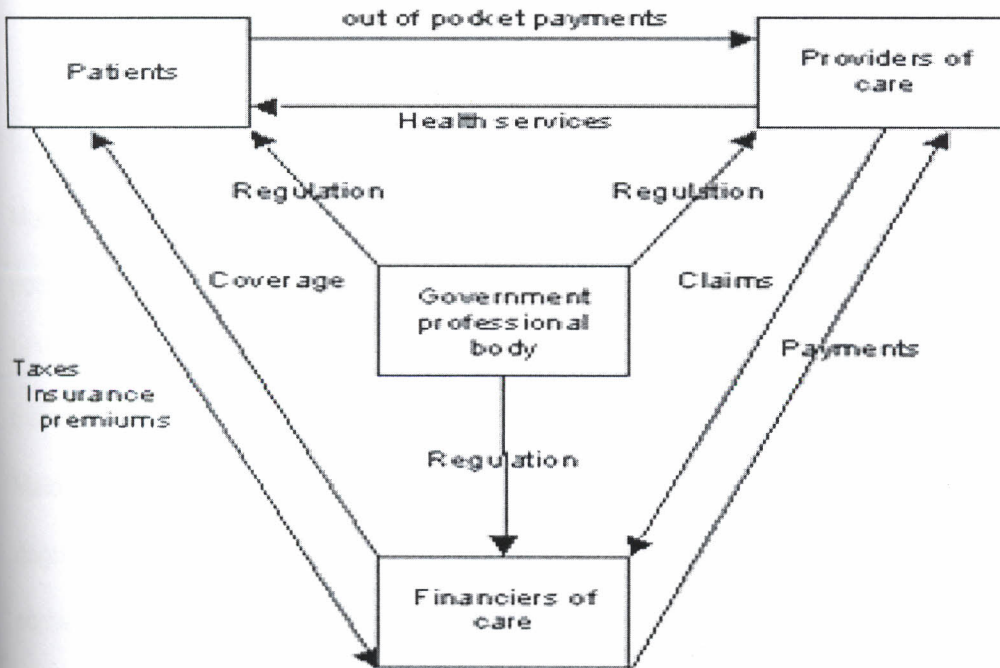
According to Ross-Degnan et al 2002; The World Bank (2003a) suggests by 40-60%. Given that pharmaceuticals account for 10-30% of recurrent public spending on health, this implies savings of around 5-15%. These are most difficult to achieve where doctors have the power to oppose generic prescribing and essential drugs lists and where there is a powerful local pharmaceutical industry (Marquez 2000). Distribution systems seem harder to reform and the means of efficient improvements are more controversial; a review of the distribution and use of pharmaceuticals in developing countries concluded that the public sector can be made to work' (Foster 2003). Others, however, disagree, arguing that on one of the strategies to improve public sector distribution systems have been particularly successful (Vogel and Stephens 2000). Even advocates of government-run essential drugs systems accept that little evidence is available of success in improving public sector prescribing practices (Ross-Degnan et al 2002).

2.7 Conceptual Model

The conceptual model of this study attempts to outline how several factors influence financing of public services especially health care and how the sector can be made productive and effective.

The Conceptual Framework Model

Figure 1



Source: Carrin G. and James C. (2005)

The proposed model is based on existing health economics models. The model integrates patients (contributors), health care providers and the government who are the financiers of health service provision. Following health economics principles developed by Carrin G. and James C. (2005), the model simulates and predicts the participation of all the independent parties in financing of public health services provision.

The model may be divided into three parts patients, health care providers, financiers of health and the Government professional bodies.

- The first part consists of patients who finance health service provision through user fees.
- The second part consists of health care providers who finance care through revenue collection.
- The third part consists of financiers of health such as ministry of finance health care through budget allocation and the Ministry of Health financiers of health through resource allocation.

Many demographers and psychologists have accepted the notion that there is considerable potential for health services, especially hospitals, to improve technical and operational financing. In hospitals, the following examples indicate that the management reforms necessary to increase funding are often fairly obvious and do not require sophisticated approaches. In Malawi, a hospital cost analysis indicated that in all six hospitals studied, there was a high degree of awareness amongst district health officers of the need to control a resource use, and some cautions in ensuring resources were used effectively (Mills 2003). However, reforms seemed to depend on the interest and energy of the senior staff, especially the district health officer who had many responsibilities and who rarely stayed for more than two or three years. One of the greatest needs was therefore to establish a cadre of hospital managers with sufficient authority to control resource use. Similar conclusions have been reached in Papua New Guinea (Thomason and Edwards 2001).

In this study it was envisaged that low utilization may be a major source of inadequate funding, and require greater attention be paid to improving aspects of performance that users value. For example, the introduction of payment to finance an essential drugs supply, and tight management and financial control, can be sufficient to have a substantial effect on utilization

without major additional external resources (Unger, Mbaye and Diao 2000). In Indonesia, it has been argued that adding a specialist and surgical services to lower-level hospitals would greatly boost use (Barnum and Kutzin 2003). What is not understood, however, are the influences leading Ministries to introduce sustained reform, and the means to inculcate managerial culture and capacity that gives priority to improved resource use.

In this study it was argued that understanding the factors that lead to under financing of public service provision should be studied so as to enable intervention policies and programmes to tackle the root cause of the problem. This study investigates the factors that contribute to inadequate funding of public health services and ways of setting up policies to improve financing of public health provision in Kenya.

This research sought to determine the challenges faced by the Ministry of Health in financing public health service provision. The researchers argued that knowledge of challenges faced in financing health service provision enables the people to understand the importance of user fee charged in public health facilities.

The study also assessed the role played by resource allocation to hospital in the provision of efficient or inefficient services. Researcher will also give recommendations of how these sectors can be improved to be more productive by introducing all inclusive health insurance scheme.

The study examined how these circumstances are affected by social, economic and demographic characteristics; these aspects of financing of public health service provision are important if the problem of equitable public health services is to be addressed, these areas of investigation have been neglected by current existing researches.

2.8 Summary of Literature Review

The studies showed that public health provision was of paramount importance to the citizens of a country, therefore adequate funding for the public health service facilities is very important. Since independent in 1963, Kenya had a predominantly tax-funded health system, but then gradually introduced a series of health financing policy changes. User charges had been in place as well but were later removed, inspired by concerns about social justice. A study carried out in Kibwezi (Dahlgren, 2000) focusing on the use of health services revealed that outpatient care increased again after the lifting of the registration fee.

Research findings have revealed a number of areas instrumental in shortcomings in the financing of health service provision. These areas includes: observed inadequacies, Bureaucratic Approaches and evidence of their success, Social and Economic Changes, Improvement in the policy process, Management system improvement and so on.

Whereas many studies on financing of public health service provision in Kenya have been carried out (Karanga et.al. 2004) the researchers have focused mainly on financing of health care provision, while giving little attention to factors affecting financing of public health service provision and the challenges faced by the stakeholders for example Ministry of Health and Ministry of Finance in the financing of public health service provision in Kenya. These should have formed an important component of such studies. This study will therefore address itself to the factors affecting financing of public health service provision the challenges faced by the stakeholders in the financing of public health centres, the study will also examine the impact of budget allocation in the health care financing.

Several health care provision studies have examined financing of community health services and the financing of reproductive health services (Kimani et. al. 2004). These studies have however, failed to examine the relationship between factors affecting financing of public health care provision.

Financing of public health service provision is of paramount importance to any country, Addressing the factors affecting the provision of health service is important and should be discussed when aiming to resolve the problem of financing health care provision in Kenya (Njeru et. al. 2004). This is addressed in this study to bridge the gap.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

In this study of the factors affecting financing of public health service provision in Kenya (Peterson et al, 2001), the data used in this research was collected as part of the larger research on public health service financing systems. Since this study focused on Ministry of Health and the Ministry of Finance purposively selected by the researcher on the basis of their involvement in the financing of public health service provision, only these Ministries were considered. In any event, this approach is not likely to bias the results given the homogeneity of the financing systems.

Within the two Ministries, the units of analyses were restricted to the staff working in the Finance Division and the Budgetary Division respectively, health care providers providers at Kenyatta National Hospital were also interviewed. The above institutions were selected, based on the availability of the staff to fill in the questionnaires, additional data was collected from selected departments within the Ministry of health; notably, Health Sector Reform Secretariat, Planning and Development and Accounts department who are involved in the improvement of financing systems to the health sector.

3.1 Study Design

The study design is the overall scheme or plan and structure with which the research project is executed. The appropriate design depends on the objectives of the research and the required data. (Peterson, 2000). Descriptive research design was adopted in this study. This is because this research design determines and reports the way things are. It attempts to describe such

things as possible behaviour, attitude, values and characteristics. This design also allows considerable amount of information to be obtained from a large sample.

3.2 Target Population

The study targeted staff of the Ministry of Health and Ministry of Finance Headquarters, the population is 1,325 and 1,566 respectively. Questionnaires were distributed to those working in Finance Budgetary Divisions and the staff of Ministry of Health Finance Division.

3.3 Sample Design

From the approximate population of 1,325 staff in the Ministry of Health and 1,566 from the Ministry of Finance a random sample of 10% will be taken. According to Mugenda and Mugenda (1999) a representative sample is one that is 10% of the population as indicated below.

Table 3.3.1 Sample Design

Category	Population Frequency	Sample Ratio	Sample
Ministry of Health Headquarters	1,325	0.1	133
Ministry of Finance Headquarters	1,566	0.1	157
Total	2,891		290

Stratified Random sampling was used. The advantages of stratified random sampling is that the researcher was able to control the sample size in the strata, it has increased statistical efficiency, it provided data to represent and analyze sub-groups and enabled the researcher to use different methods in the strata.

3.4 Data Collection Instruments

The researcher constructed the questionnaires relevant to the research as a data collection instrument. Questionnaires included structured and non-structured questions.

3.5 Data Collection Procedure

The study utilized both primary and secondary data. The research started by reviewing literature on public health service financing and management with a focus on public health care delivery in Kenya and a few other countries. After this, relevant tools were designed to facilitate primary data collection from the study areas on issues touching on financing of public health service provision, the challenges Ministry of Health faces in the financing of public health service provision, and the impact of budget allocation to the Ministry of Health. The research instruments employed included: structured questionnaires, face to face discussions and the observation guides. After the preparation of these instruments, they were pre-tested by the researcher, later refined, before their use in the actual survey. The researcher was responsible for the data collection, Through the delivery and picking later method, the research tools were finalized and the modalities of data collection, including sampling framework developed. With the help of few volunteers the instruments were administered to the respondents, thereafter procedures were developed for data analysis.

3.6 Data Analysis Techniques

The research relied heavily on qualitative data analysis, which proceeded as follows: Firstly, the responses from the field were summarized and coded in line with the set questions from the questionnaire, This necessitated the construction of summary sheets containing data on the key variables sought (for example Factors Affecting financing of public health service provision, challenges faced by the Ministry of health in financing public health service provision, and the inequity in budget allocation). Secondly, interim coding were prepared to communicate the

findings on the respective objectives. Thirdly a sequential analysis was undertaken to provide a much deeper insight into the data collected, The analysis was on the percentage basis by use of management software statistical package for social scientists (SPSS), to ensure the confidentiality requested by the respondents. An attempt was made to desist as much as possible from providing the opinion of individual respondents. Percentages was used to determine the magnitude of issues dealt within the research, while the frequency tables were used to determine the number of people who responded to the research questions and also to check the skewness of the data. The analysis was conducted on the basis of research questions formulated. The presentation of the results and the interpretation of the findings were also based on the findings of the study.

CHAPTER FOUR

4.0 DATA ANALYSIS, FINDINGS AND INTERPRETATION

4.1 Introduction to Data Analysis

Data was collected through questionnaires, which were administered to the respondents using hard copies sent by hand and soft copies sent via electronic mail. The sample population included employees in the Ministry of Health Finance Division and the Ministry of Finance Budgetary Division who were categorized health workers who were categorized in the others groups.

4.2 Quantitative Analysis

In the study the following groups of respondents were asked to state their designations, the results that were obtained are shown in table 4.2.1.

Table 4.2.0 Frequency Distribution of the Designation of the Respondents

	Frequency	Percent
Estimate Officer	15	5.6
Public Relations Officer	10	8.3
Accountant	30	16.7
Other	50	50.0
Total	105	80.6
Did not Answer	7	19.4
Total	112	100.0

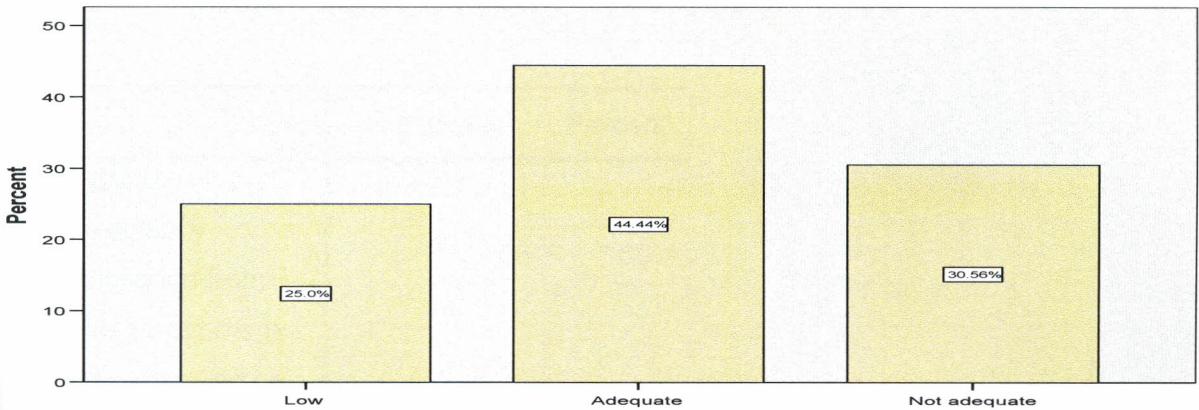
Table 4.2.1 Level of Financing Public Health care over the past twelve months

In the study the respondents were asked to state the level of financing public health care over the past twelve months, the results that were obtained are shown in table 4.2.1

Table 4.2.1 Frequency Distribution of the Level of Financing Public Health Care over the past twelve Months.

	Frequency	Percent
Low	25	25.0
Adequate	40	44.4
Not adequate	30	30.6
Total	95	100.0

Level of financing public health care over the past 12 months



The results on table 4.2.1 show that fewer than half of the respondents stated that level of financing public health care has been adequate 44.4%, while 30% of the respondents believes that the level of financing public health care is not adequate, 25% felt that the level is still low over the past twelve months. This implies that the level of funding over the last twelve months has been adequate according to the results obtained from the study.

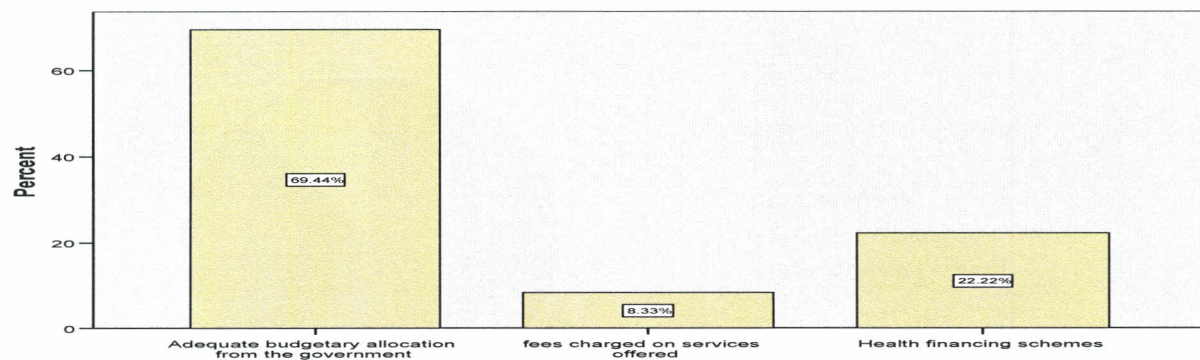
4.2.2 Health Financing Measures needed to improve sustainability and performance of Kenyan Health System.

The results on table 4.2.2. shows that 69.4% of the respondents believes that adequate budgetary allocation from the Government will help in improving Kenya’s health system. The results also shows that 22% of the respondents felt that health financing schemes could help in improving public health care provision in Kenya, 8% of the respondents believe that fees charged on service offered may boost performance of Kenyan health systems. This implies that the best measure needed to improve sustainability and performance of Kenyan health system financing would be adequate budgetary allocation from the government as observed by the majority of the respondents.

Table 4.2.2 Frequency Distribution of Health Financing Measures needed to improve sustainability and performance of Kenyan Health System.

	Frequency	Percent
Adequate budgetary allocation from the government	50	69.4
fees charged on services offered	15	8.3
Health financing schemes	25	22.2
Total	90	100.0

health financing measures needed to improve sustainability and performance of Kenyan health systems



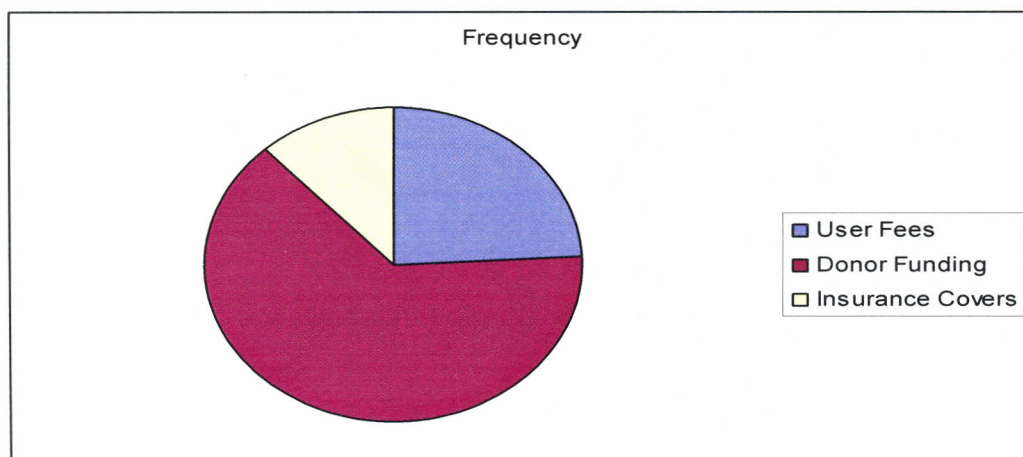
4.2.3 Other sources of financing public health care provision other than budget allocation

The results in table 4.2.3 shows that more than half of the respondents 51.6% believe that Donor funding was one of the major source of financing public health care provision other than the budget allocation 51.6%, while 22.2% felt that Insurance covers was the best source, 19.4% also felt that User fee is the best source, 13.9% did not answer the question. The results implies that the other sources of financing public health care provision other than budget allocation as revealed in the study is donor funding.

Table 4.2.3 Frequency Distribution of other sources of financing public health provision other than budget allocation.

	Frequency	Percent
User Fees	20	19.4
Donor Funding	53	51.6
Insurance covers	10	22.2
Total	83	86.1
No Answer	5	13.9
Total	88	100.0

Sources of financing public health provision other than budget allocation



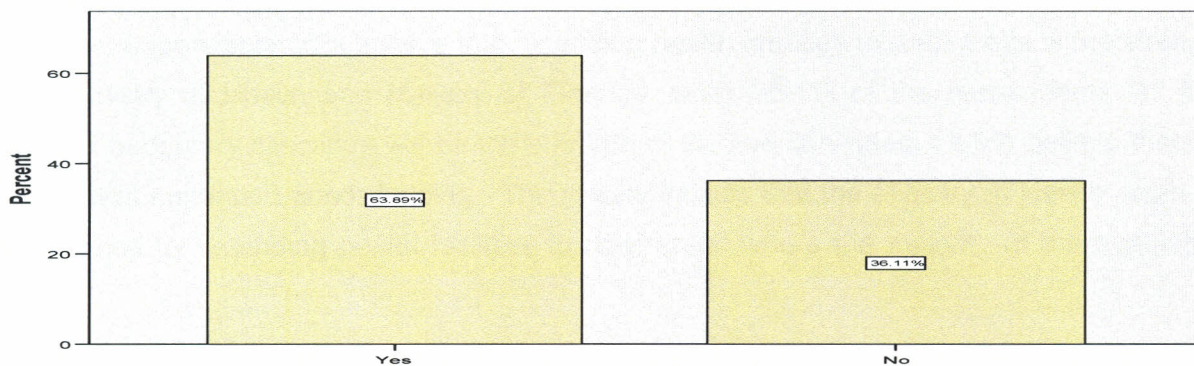
4.2.4 Are people willing to pay for health services?

Sixty-three percent of the respondents agree that people are always willing to pay for health services 63.9%, while 36.1% felt that people are not always willing to pay for health care services, for those who felt that people are not willing to pay for health care services indicated that majority of Kenyans live below the poverty line and could not afford service charges. This implies that people usually have no problem paying for health services despite the financial difficulties faced by the majority of the citizens, the results also implies that the health care services are paramount hence the people's willingness to pay for the services.

Table 4.2.4 Frequency Distribution of people willingness to pay for health services.

	Frequency	Percent
Yes	56	63.9
No	33	36.1
Total	89	100.0

Are people willing to pay for health services?



4.2.5 Response towards user fees

The results on table 4.2.5 shows that the majority of the respondents 58.8% believe that the response towards user fees has been fair, 16.7% of the respondents felt that the response was poor, 19.4% felt that response was good, 5.6% did not answer. Almost all the respondents did not know the date when user fee started in public health facilities. The results implies that response towards user fees has not been good as revealed by the majority of the respondents, most of the users felt it was the duty of the government to finance public health care services, hence the negative response towards the user fees.

Table 4.2.5 Frequency Distribution of Response towards user fees

	Frequency	Percent
Very good	5	2.8
Good	25	19.4
Fair	65	58.8
Poor	15	16.7
Total	110	94.4
Did not answer	2	5.6
Total	112	100.0

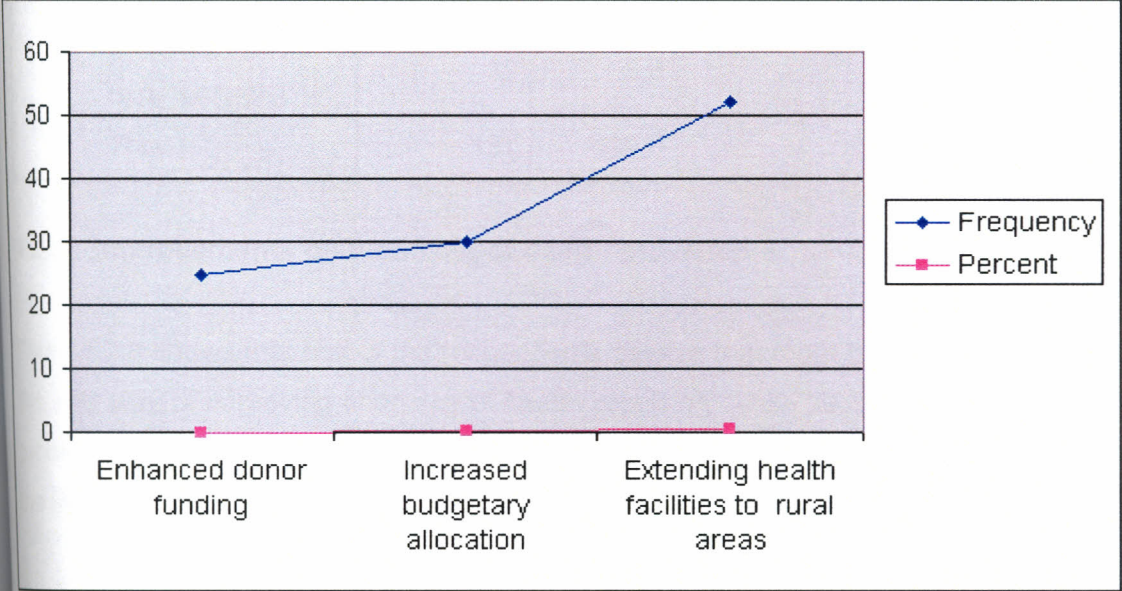
4.2.6 The strength of Ministry of Health and Ministry of Finance in financing of public health provision?

Half of the respondents 50% believe that extending health facilities to rural areas is the strength of the Ministry of Health and Ministry of Finance, while 36.1% of the respondents felt that increased budgetary allocation will be the strength of the two Ministries, 13.9% believe that the strength was enhanced donor funding. The results implies that the Ministry of Health could be strengthened by extending health facilities to rural areas where the majority of the population lives.

Table 4.2.6 Frequency Distribution of the strength of Ministry of Health and Ministry of Finance in the financing of public health provision.

	Frequency	Percent
Enhanced donor funding	25	13.9
Increased budgetary allocation to health	30	36.1
Extending health facilities to rural areas	52	50.0
Total	107	100.0

The strength of Ministry of Health and Ministry of Finance in the financing of public health provision.



4.2.7 Challenges faced by Ministry of Health in financing of public health provision

Majority of the respondents 41.7% believe that corruption in the distribution of drugs was the major challenge in financing of health provision, while 27.8% felt that Brain drain in health sector is a major challenge, 16.7% of the respondents felt that political interference was a big challenge, 8.3% think that User fees defaulters are major challenges, while 5.6% felt that insufficient health care services is a challenge facing Ministry of health. This implies that corruption in the distribution of drugs is the main challenge facing the Ministry of Health in financing of public health provision, most of the public health centres does not receive adequate drugs, hence hindering the effective delivery of health services.

Table 4.2.7 Frequency Distribution of Challenges faced by Ministry of Health in financing of public health provision.

	Frequency	Percent
Political interference	36	16.7
Corruption in distribution of drugs	45	41.7
Brain drain in health sector	25	27.8
User fees defaulters	13	8.3
Inefficient health care services	12	5.6
Total	131	100.0

4.2.8 Improvements on financing of health provision

Table 4.2.8 shows that half of the respondents believe that more budget allocation to health was the only way of improving financing of health provision, while 19.4% of the respondents felt that proper management of health funds will help in improving financing of health provision, 16% of the respondents felt that staff motivation will help in improving financing of health care provision,

13.9% were not sure. The results implies that increased budget allocation would improve help in improving the financing of health provision.

Table 4.2.8 Frequency Distribution of Improvement of financing of health provision.

	Frequency	Percent
More Budget Allocation	45	50.0
Staff Motivation	26	16.7
Proper management of funds	32	19.4
Others	15	13.9
Total	118	100.0

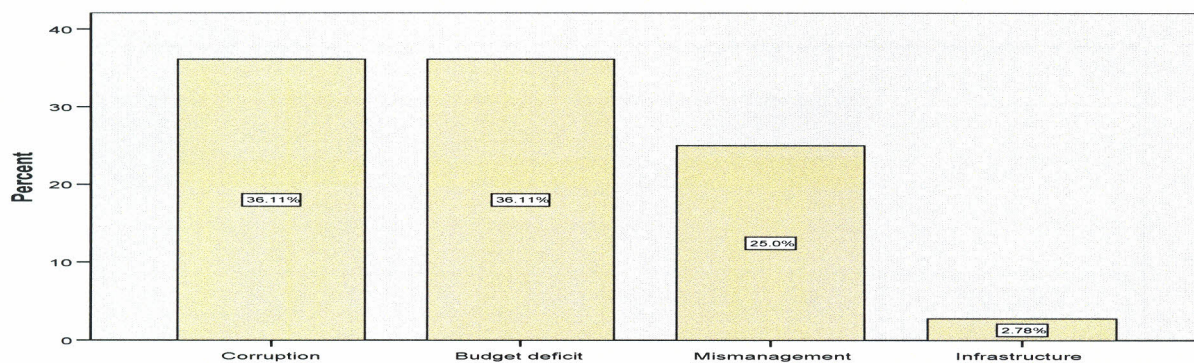
4.2.9 Factors affecting financing of public health care provision in Kenya

Thirty-six percent of the respondents believes that corruption and budget deficit are the major factors affecting financing of public health care provision in Kenya, 25% felt that mismanagement also affect financing of public health care provision, 2.8% felt it is infrastructure which affects financing of public health care provision in Kenya. The results above implies that corruption and the budget deficit are the major factors affecting financing of public health service provision in Kenya.

Table 4.2.9 Frequency Distribution of Factors affecting public health care provision in Kenya

	Frequency	Percent
Corruption	43	36.1
Budget deficit	43	36.1
Mismanagement	20	25.0
Infrastructure	3	2.8
Total	109	100.0

What do you think are the factors affecting financing of public health care provision in Kenya?



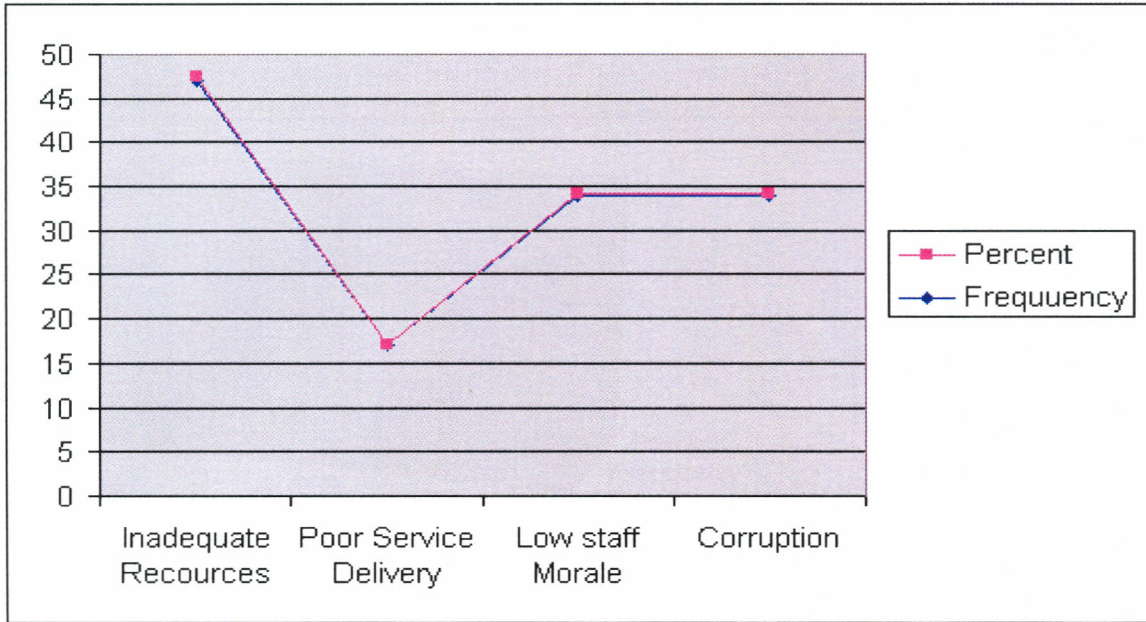
4.2.1.1 Reasons why inequity in Budget allocation affects financing of public health service provision

Table 4.2.1.1 shows that 47.2% of the respondents believe that inadequate resources are the reasons affecting financing of public health service provision, while 19.4% felt that low staff morale and corruption affects financing of public health service provision, 11.1% of the respondents felt that poor service delivery are the reasons why inequity in budget allocation affects financing of public health service provision. This implies that inadequate resources are the major problems affecting financing of public health service provision in Kenya, while other factors only play a minor role.

Table 4.2.1.1 Frequency Distribution of the reasons why inequity in Budget allocation affects financing of public health service provision

	Frequency	Percent
Inadequate Resources	47	47.2
Poor Service Delivery	17	11.1
Low staff Morale	34	19.4
Corruption	34	19.4
Others	2	2.8
Total	134	100.0

The four main reasons why inequity in Budget allocation affects financing of public health service provision



4.2.1.2 Problems in financial allocation to provide health services

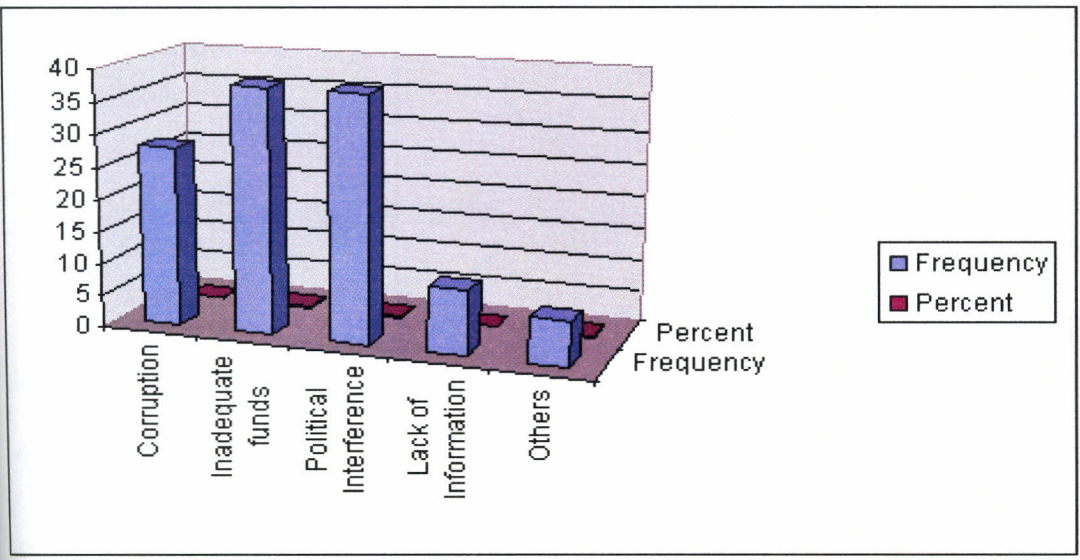
Twenty-five percent of the respondents believe that inadequate funds and political interference are the major problems of financial allocation to health, 22% felt the problem is corruption, while 8.3% felt is lack of information. 19.4% were not sure. The results implies that the main problems of financing public health service provision is mainly political interference and inadequate funds, it seems most of the correspondents felt corruption is not a major problem.

Table 4.2.1.2 Frequency Distribution of problems encountered when allocating financial resources to health care provision

	Frequency	Percent
Corruption	28	22.2
Inadequate funds	38	25.0
Political interference	38	25.0
Lack of Information	10	8.3
Others	7	19.4
Total	131	100.0

Other problems included poor infrastructure such as roads to access the rural areas, electricity and also lack of technical know how by the people doing allocation.

The problems encountered when allocating financial resources to health care provision



4.2.1.3 Why inequity in Budget allocation affect financing of public health service provision

The results shows that forty-seven percent of the respondents believes that inequity in budget allocation will lead to inadequate resources in the financing of public health service provision, 19.4% felt that it will lead to low staff morale and increase also the incidences of corruption in the health sector, while 11% felt that it will lead to poor service delivery, 2.8% were not sure as indicated in table 4.2.1.3. This implies that inequity in budget allocation often leads to inadequate resources in the financing of public health service provision in Kenya.

Table 4.2.1.3 Frequency Distribution Table of why inequity in Budget allocation affect financing of public health service provision

	Frequency	Percent
Inadequate Resources	52	47.2
Poor Service Delivery	12	11.1
Low staff Morale	25	19.4
Corruption	25	19.4
Others	4	2.8
Total	118	100.0

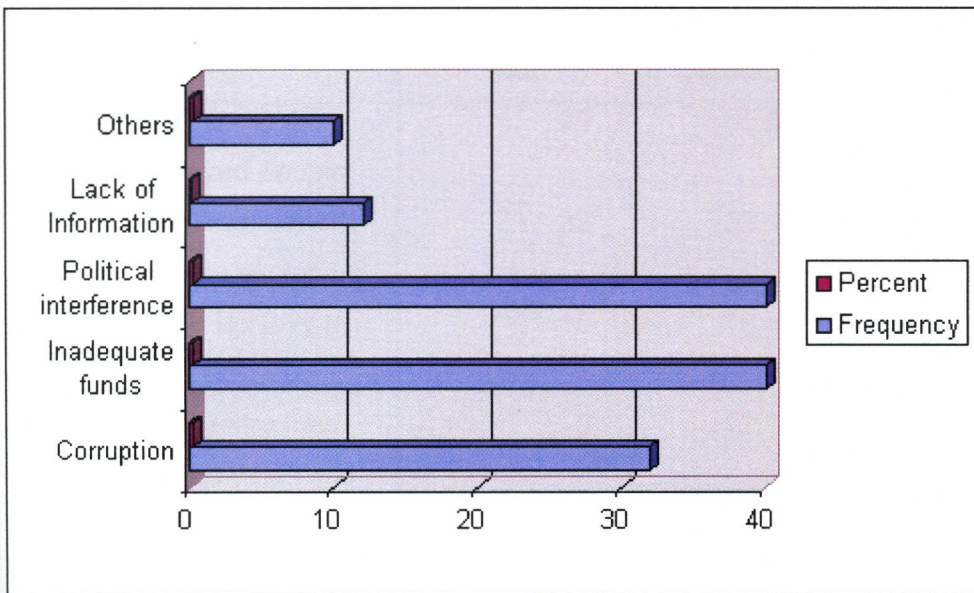
4.2.1.4 Problems in financial allocation to provide health services

Result shows that twenty five percent of the respondents believe that inadequate funds and political interference are the major problems in allocation to provide health services, which 32% of the respondents felt that corruption is the problem, 12% cited lack of information as the problem, 19.4% were indifference. Other problems included poor infrastructure such as roads to access the rural areas, electricity and also lack of technical know how by the people doing allocation. The results implies that budget allocations to public health services are affected by inadequate funds and political interference.

Table 4.2.1.4 Frequency Distribution of problems in financial allocation to provide health services

	Frequency	Percent
Corruption	32	22.2
Inadequate funds	40	25.0
Political interference	40	25.0
Lack of Information	12	8.3
Others	10	19.4
Total	134	100.0

Problems in financial allocation to provide health services



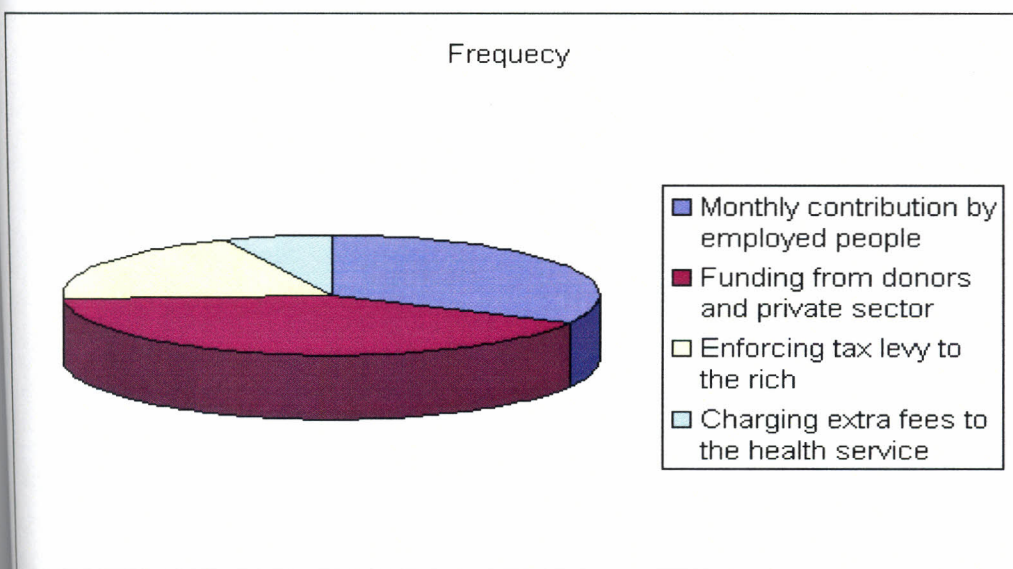
What the Government should do to tap potential sources of finance for public health facilities

Result shows that majority of the respondents 38.9% felt that funding from donors and private sector are some of the potential sources the government can tap, while 30.6% felt that monthly contribution by the employed people is also vital, 19.4% of the respondents felt that enforcing tax levy to the rich could also be explored as one of the potential sources, 11.1% felt that charging extra fees to the health service may boost the government potential. The results above implies that the potential sources the government can explore in order to tap finances for the funding of public health care services is funding from donors and private sector.

Table 4.2.1.5 Frequency Distribution of what the Government should do to tap potential sources of finance for public health facilities.

	Frequency	percent
Monthly contribution by employed people	25	30.6
Funding from donors and private sector	32	38.9
Enforcing tax levy to the rich	15	19.4
Charging extra fees To the health service	5	11.1
Total	77	100.0

What the Government should do to tap potential sources of finance for public health facilities.

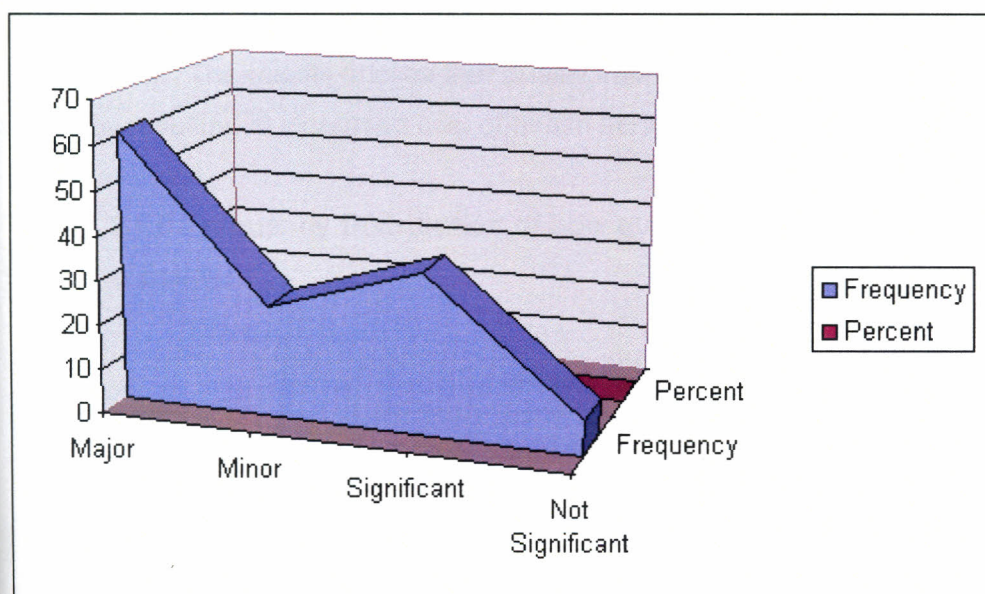


Results shows that majority of the respondents believe that quality plays a major role in health financing measures 47.2%, while 27.8% felt that it just plays a minor role, 16.7% agrees that quality plays a significant role in health financing, 8.3% felt the role quality plays in health financing measures is not significant. The results implies that equity plays a major role in health financing measures.

Table 4.2.1.6 Frequency Distribution of the role quality plays in health financing measures.

	Frequency	Percent
Major	61	47.2
Minor	25	16.7
Significant	36	27.8
Not Significant	8	8.3
Total	129	100.0

What role does quality play in health financing measures



4.2.1.6 Have user fee revenues been used to pay for quality improvement

Thirty-eight percent of the respondents disagree that user fee revenues has been used to pay for quality improvement, while 27.8% agree that it has been used to improve quality, 33.3% were not sure. The result implies that user fees revenue has not been used effectively for quality improvement in the public health sector.

Table 4.2.1.7 Frequency Distribution on have user fee revenue been used to pay for quality improvement.

	Frequency	Percent
Yes	20	27.8
No	42	38.9
Not sure	37	33.3
Total	99	100.0

4.2.1.7 How do quality improvements affect costs and financing policy

The results shows that 44.4% of the respondents agrees that quality improvements affect costs and financing policy, cost of health services will increase, 25% of the respondents felt that when quality is improved accessibility of health facilities will be hindered, 30.6% felt that health budget will increase. The results implies that quality improvements actually affects costs and financing policy by resulting in increased cost of health services.

Table 4.2.1.8 Frequency Distribution of how quality improvements affect costs and financing policy.

	Frequency	Percent
High cost of health Services	56	44.4
Accessibility of health Facility will be hindered	25	25.0
Health budget will increase	15	30.6
Total	96	100.0

4.2.1.8 How can government better use their budget to improve their peoples health

Majority of the respondents believe that the government can better use their budgets to improve their peoples health by enacting health policy that is flexible to all 44.4%, while 41.7% of the respondents felt that the can do it by increasing number of dispensaries and health centres, while 11.1% agree that they can do this by buying drugs for distribution. This implies that

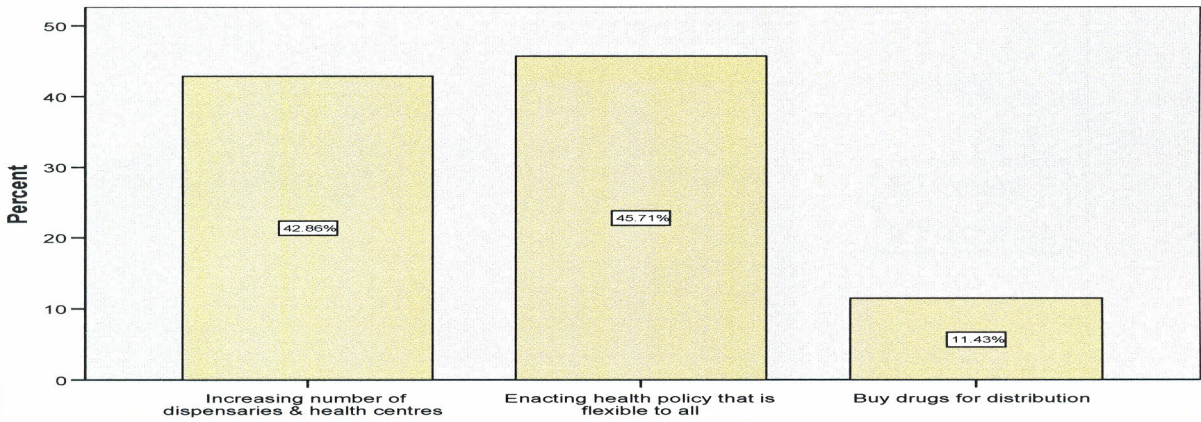
majority of the respondents expect the government to better use their budgets to improve their people's health by enacting health policy that is flexible to all.

Table 4.2.1.9 Frequency Distribution of how the government can better use their budgets to improve their peoples health

How can government better use their budgets to improve their peoples health?

	Frequency	Percent
Increasing number of dispensaries & health centres	48	41.7
Enacting health policy that is flexible to all	52	44.4
Buy drugs for distribution	15	11.1
Total	115	100.0

How can gov. better use their budgets to improve their peoples health?



4.2.2.1 Can hospital autonomy help government reduce hospitals share of the public health budget in favour of primary health care.

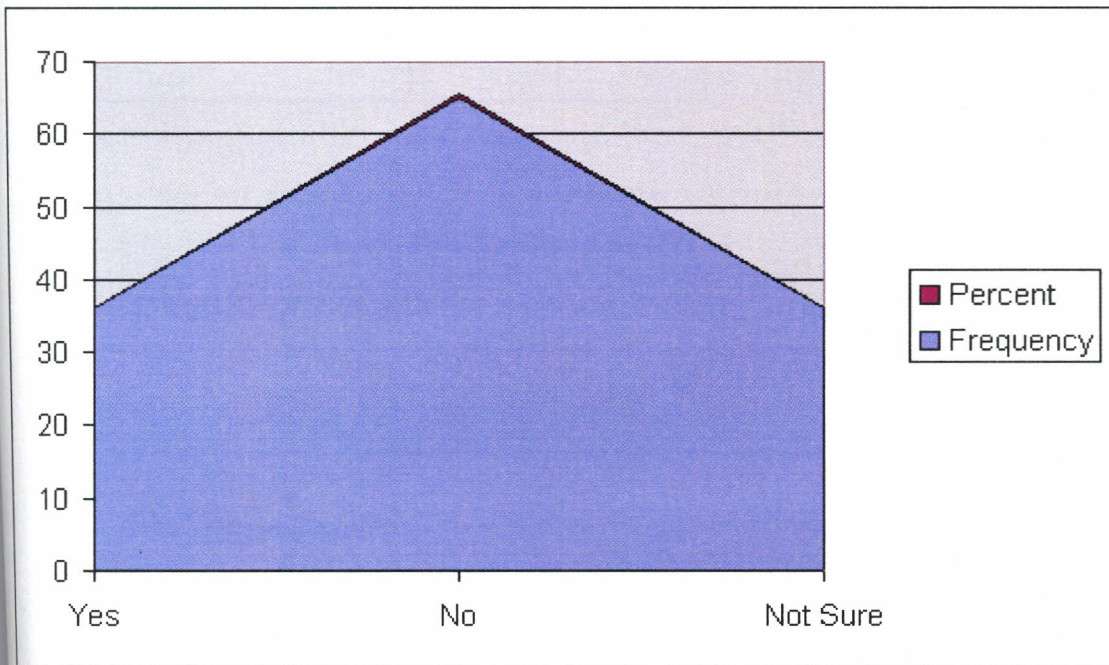
Result shows that majority of the respondents agree do not agree that hospital autonomy can help government reduce hospitals share of the public health budget 61.1%, while 19.4% felt that

it will help the government, 19.4% of the respondents were not sure. This implies that hospital autonomy does not play a major role in reducing hospitals share of the public health budget.

Table 4.2.2.1 Frequency Distribution of how hospital autonomy can help government reduce hospitals share of the public health budget in favour of the primary health care

	Frequency	Percent
Yes	36	19.4
No	65	61.1
Not sure	36	19.4
Total	137	100.0

Can hospital autonomy help the government reduce hospitals share of the public health budget in favour of the primary health care.



4.2.2.2 Ways for sharing the risks or easing the burden of paying for health care

Forty-four percent of the respondents believe that enacting policy of health financing scheme for all people would ease the burden of paying for health care, 36.1% of the respondents felt that

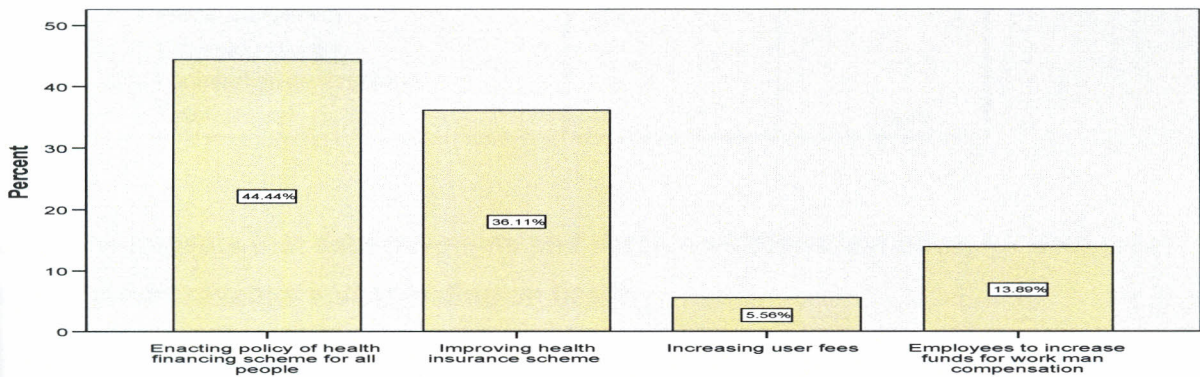
improving health insurance scheme would help in sharing the risks or easing the burden of paying for health care, while 13.9% felt that increasing the employees funds for work man compensation would help in easing the burden of paying for health care, 5.6% thinks that increasing user fee would health. The results implies that enacting policy of health financing scheme for all people would ease the burden of paying for health care.

Table 4.2.2.3 Frequency Distribution of ways for sharing the risks or easing the burden of paying for health care

The main ways for sharing the risks or easing the burden of paying for health care

	Frequency	Percent
Enacting policy of health financing scheme for all people	52	44.4
Improving health insurance scheme	44	36.1
Increasing user fees	7	5.6
Employees to increase funds for work man compensation	25	13.9
Total	126	100.0

Main ways for sharing the risks or easing the burden of paying for health care



4.2.2.4 The political forces that must be dealt with and strategies which are most likely to succeed at national level to achieve greater equity in health

The results on table 4.2.2.4 shows that more than half of the respondents agree that enacting laws that lead to equitable health care would succeed to achieve greater equity in health 52.8%, while 38.9% of the respondents felt that implementing free health care policy would be the best strategy, 8.3% also felt that enforcing monthly contribution by everyone would be the way forward. The results implies that enacting laws that lead to equitable health care would succeed to achieve greater equity in health care service provision in Kenya.

Table 4.2.2.4 Frequency Distribution of the political forces that must be dealt with and strategies which are most likely to succeed at national level to achieve greater equity in health.

The political forces that must be dealt with and strategies which are most likely to succeed at national level to achieve greater equity in health

	Frequency	Percent
Enacting laws that lead to equitable health care	67	52.8
Facilitation in implementing free health care policy	42	38.9
Enforcing Monthly contribution by everyone	12	8.3
Total	121	100.0

4.2.2.5 The impacts that debt payments and harsh conditions laid down for debt relief have on public revenue and spending on health

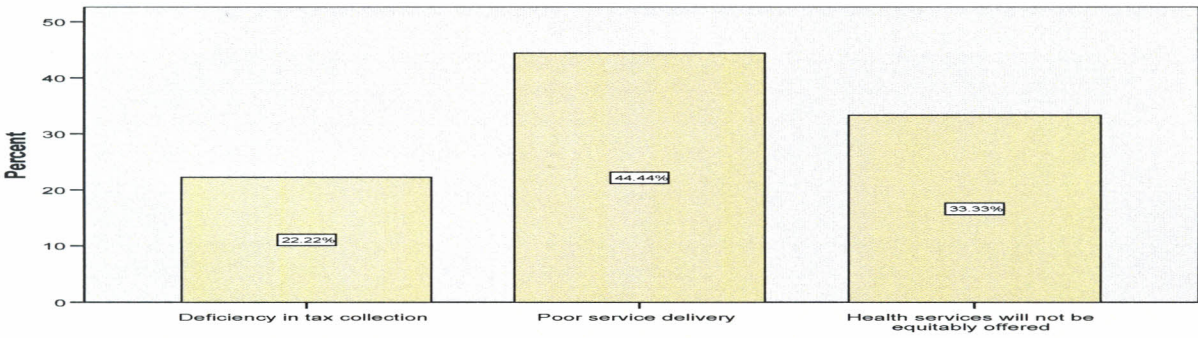
Forty-four percent of the respondents believe that debt payments and harsh conditions laid down for debt relief would lead to poor service delivery because of lack of funds, other results shows that health services will not be equitably offered 33.3%, while 22.2% of the respondents felt that it would lead to deficiency in tax collection. The results implies that debt payments and harsh conditions laid down for debt relief would lead to poor service delivery due to lack of funds.

Table 4.2.2.5. Frequency Distribution of the impacts that debt payments and harsh conditions laid down for debt relief have on public revenue and spending on health.

The impacts that debt payments and harsh conditions laid down for debt relief have on public revenue and spending on health

	Frequency	Percent
Deficiency in tax collection	15	22.2
Poor service delivery	53	44.4
Health services will not be equitably offered	36	33.3
Total	104	100.0

The impacts debt payments and the harsh conditions laid down for debt relief have on public revenue & spending on health



4.2.2.6 How levels, conditions and effectiveness of donor funding influence health equity

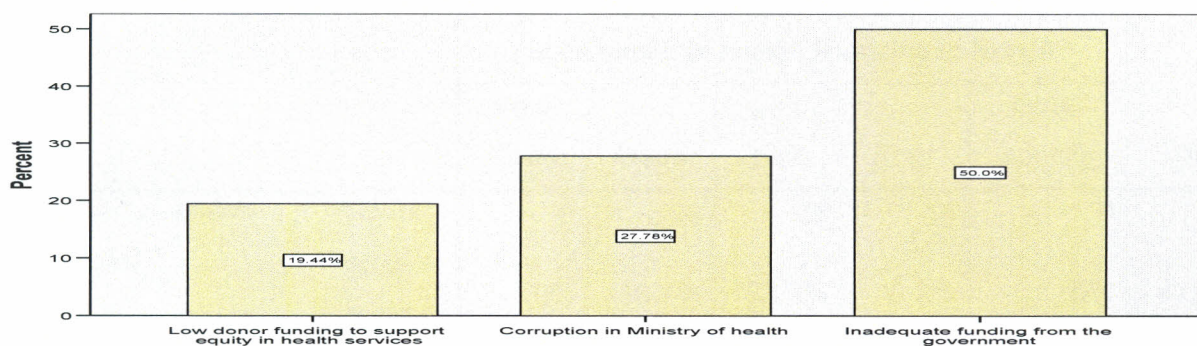
The results shows that 50% of the respondents believe that levels, conditions and effectiveness of donor funding greatly influence health equity leading to inadequate funding from the government, while 27.8% of the respondents felt that it would lead to corruption in the Ministry of health, 19.4% of the respondents felt that it leads to low donor funding to support equity in health services. This implies that levels, conditions and effectiveness of donor funding greatly influence health equity and usually leads to inadequate funding from the government.

Table 4.2.2.6 Frequency Distribution of how levels, conditions and effectiveness of donor funding influence health equity

How levels, conditions & effectiveness of donor funding influence health equity

	Frequency	Percent
Low donor funding to support equity in health services	27	19.4
Corruption in Ministry of health	32	27.8
Inadequate funding from the government	80	50.0
	1	2.8
Total	139	100.0

How the levels, conditions & effectiveness of donor funding influence health equity



4.2.3.5 The current status of public health provision financing in Kenya

The results shows that 38.9% of the respondents agrees that the current health status is good and some felt is fair, 16.7% of the respondents felt that it is fair, while 2.8% felt it has been fair.

Table 4.2.2.7 Frequency Distribution of the current status of public health provision financing in Kenya

The current status of public health provision financing in Kenya

	Frequency	Percent
Very Good	5	2.8
Good	47	38.9
Fair	47	38.9
Poor	25	16.7
Other specify	5	2.8
Total	129	100.0

Correlation

Table 4.2.2.8 Comparison between what role quality plays in health financing measures and the current status of public health provision financing in Kenya

			How would you describe the current status of public health provision financing in Kenya?					Total
			Very Good	Good	Fair	Poor	Other specify	
What role does quality plays in health financing measures?	Major	Count	0	26	36	15	0	77
		% of Total	.0%	16.7%	22.2%	8.3%	.0%	47.2%
	Minor	Count	7	12	27	10	10	66
		% of Total	2.8%	5.6%	2.8%	2.8%	2.8%	16.7%
	Significant	Count	0	26	10	5	0	41
		% of Total	.0%	16.7%	8.3%	2.8%	.0%	27.8%
	Not significant	Count	0	0	15	5	0	20
		% of Total	.0%	.0%	5.6%	2.8%	.0%	8.3%
	Total	Count	7	64	88	35	10	204
		% of Total	2.8%	38.9%	38.9%	16.7%	2.8%	100.0%

The respondents agreed that they believe quality plays a major role in health financing because people may tend to seek health services in facilities where the quality of service is guaranteed, this would result in increased revenue and hence increased finances maintain the quality of care. The results in table 4.2.2.8 give a comparison between the role of quality and current status of public health provision financing in Kenya.

The finding on table 4.2.2.8 shows that quality and the current status of public health financing are interrelated, every step the government takes to increase budgetary allocation to the Ministry of Health has been to improve quality of service in the public health facilities, therefore the respondents felt that quality usually plays a major role 22.2% in the current status, coming to a total of 47.2% of the overall rating, which reveals that the majority of the respondents believe quality plays a major role. The research further attempted to identify the correct role quality plays in the financing of health compared to the current status of public health financing in Kenya, the results obtained were as shown in table 4.2.2.8 above.

4.3 Qualitative Analysis

Financing of public health service provision in Kenya over the past twelve months according to the results has been adequate. There have been both favourable and unfavourable opinions about factors affecting financing of public health service provision in Kenya, and have suggestions on how to improve certain aspects of the financing system. Respondents expressed their views about these factors and the challenges faced by the Ministry of Health in financing of public health service provision.

The results show that health financial measures needed to improve financing of public health service provision would be to provide adequate budgetary allocation from the government. The government also needs to explore other sources of funding public health care provision by enhancing donor funding in order to improve the quality of health care.

The results show that people are always willing to pay for health services so long as the quality of health care is guaranteed. Respondents agreed that response towards user fees to improve health revenue was not good. Asked whether they know when user fees started in Kenya, almost all respondents did not know the date when user fees started in public health facilities.

The study also revealed that Ministry of Health and Ministry of Finance would boost their strength by extending health facilities to rural areas specially the remote parts of the country where the access to health facilities has been very difficult. Other results also shows that the main challenges faced by the Ministry of Health in financing of public health service provision has been corruption in the distribution of drugs and brain drain in the health sector.

The results revealed that improvement in financing of health provision could be by giving more budget allocation and proper management of funds in the health sector, while other findings revealed that corruption, budget deficit and mismanagement are the main factors affecting financing of public health service provision in Kenya. The results also revealed that inequity in budget allocation affects financing of public health service provision by leading to inadequate resources in terms of monetary and equipments, it also leads to low staff morale and corruption in the health sector.

The results revealed that problems in financial allocation to provide health services has been mainly inadequate funds and to some extent political interference, corruption was also cited as one of the problems experienced when allocating funds to the public health services. It was also revealed in the research that the government can be able to tap potential sources of finance for public health facilities through enhancing monthly contribution by employed people, funding from donors and from the private sectors.

Respondents also agreed that quality plays a major role in health service financing measures, hospitals would be able to raise more revenue when the quality of their services are improved, while other people also felt that user fee revenue has not been used to pay for quality improvement in the public health facilities. Most of other respondents also observed that quality improvements usually affects costs and financing policy, it would lead to high cost of health services, increased budget allocation by the government to maintain the quality improvement.

The results also revealed that the government can use their budget to improve the health of their people by enacting health policy that is flexible to all and by increasing the number of dispensaries and health centres. Majority of the respondents in the study also observed that hospital autonomy can not help the government reduce hospitals share of the public health budget, while others believe that the main ways for sharing the risks or easing the burden of

paying for health care would be by enacting policy of health financing scheme for all people and by improving health insurance schemes affordable by all people.

Respondents believe that to overcome challenges of political interference, laws need to be enacted that lead to equitable health care and facilitation in implementing free health care policy. The research also revealed that impacts that debt payment and harsh conditions laid down for debt relief usually have a negative impact on public health service provision because it leads to poor service delivery and makes health service not being offered equitably, while other results revealed that levels, conditions and effectiveness of donor funding usually influence health equity by affecting funding from the government and sometimes leading to corruption in the Ministry of Health.

The results also revealed that the current status of the financing of public health service provision in Kenya has been good, while other respondents agree that when one compares the role quality plays in health financing measures and the current status of public health provision financing in Kenya, the results show that quality plays a major role in public health care financing.

4.4 Summary of Data Analysis

The following areas were analyzed in the study, levels of financing public health care in Kenya, health financing measures needed to improve sustainability and performance, other sources of financing public health care provision other than budget allocation, people willingness to pay for health services, response towards user fees, the strength of Ministry of Health and Ministry of Finance in financing of public health service provision, challenges faced by the above Ministries, factors affecting financing of public health care provision in Kenya, inequity in budget allocation, problems encountered when allocating financial resources to health care provision, the role equity plays in health financing measures, user fee revenues, hospitals autonomy, political forces, donor funding, comparisons between quality and the current status of public health provision financing in Kenya.

In all the questions raised it was noted that there are a number of factors affecting financing of public health care provision in Kenya such as corruption, inadequate resources, mismanagement, political interference, brain drain in the health sector, user fee defaulters, inefficient health care services, infrastructure, lack of information and so on. The designs took

into account the resource constraints, expected excess demand, which required expansion and development in provider and administrative capacities and consensus amongst all the stakeholders, financing of public health service provision and sustainability came out as key concerns in design and implementation.

The level of economic progress of a country has a bearing on the extent to which financing of public health care provision can be successful and sustainable. In terms of health care spending as a percentage of GDP, Kenya (4.5 percent) compares closely with Phillippines (3.5 percent), Germany (10.5 percent) and the United Kingdom (6.8 percent) have a higher percentage spending. Kenya's public expenditure in health has a percentage of total expenditure as of 2005 (25 percent) is low, compared to that of

Phillippes (45.9 percent), Germany (75.8 percent) and the United Kingdom (83.3 percent), Kenya's per capita total health expenditure (\$21) is also low in relation to that of Phillippe (\$541), Germany (\$2,697) and the United Kingdom (1,499). From the above analysis Kenya compares poorly to other countries in relation to financing of public health service provision.

4.5 Findings

The research found out that adequate resources are critical to sustainable provision of health services. The Kenya framework of 1994 identified several methods of health service financing, including taxation, user fee, donor funds, and health insurance. These methods have evolved into important mechanisms for funding health services in the country. They should reflect the cost of service provision as well as the ability of the population to pay. In the non-governmental sector, health services are financed primarily through the revenue collected from fees and insurance premiums charged to service users. These and based on service provision and ability to pay.

The research also revealed that the main factors influencing financing of public health care provision in Kenya are corruption in the government specifically at the Ministry of health concerning distribution and acquisition of drugs, other factors pointed out in the research includes budget deficit and mismanagement . The research also found out that some of the challenges Ministry of health needs to deal with to overcome the difficulties in financing public health service provision includes, political interference sometime politicians tend to influence the

way funds are allocated to some areas, this trend should stop if Kenya hopes to provide equitable financing of health service provision. Other challenges revealed in research are corruption in distribution of drugs, brain drain and user fee defaulters.

The research findings also revealed that the under-financing of the health sector has thus reduced its ability to ensure an adequate level of service provision to the population. The Government of Kenya funds the health sector through budgetary allocations to the Ministry of Health is not adequate enough to cater for effective financing of public health provision. However, tax revenues are unreliable sources of health finance, because of macroeconomic conditions such as poor growth, national debt, and inflation, which often affect health allocations. A manifestation of the health budget shortfalls is the widespread lack of adequate drugs and pharmaceuticals, staff shortages, and poor maintenance of equipment, transport, and facilities. Over the past two decades, the government has pursued a policy of cost sharing to bridge the gap between actual budgets and the level of resources needed to fund public health sector activities. The revenue from the cost-sharing programme has continued to grow in absolute terms and as a percentage of the recurrent government budget. Although majority of the respondents felt that revenues collected from user charges has not been used well in improving quality of health service provision.

In comparison between what role quality plays in health financing measures and the current status of public health provision financing in Kenya, the findings revealed that quality plays a major role in the financing of public health service provision in Kenya, additional funds are always desired in the health sector mainly to improve the quality of service in the public health facilities.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATION

5.1 Answers to Research Questions

This study attempted to answer the following empirical questions

- ❖ What are the factors influencing financing of public health service provision in Kenya?
- ❖ What are the challenges faced by the Ministry of Health in financing public health service provision?
- ❖ Does inequity in budget allocation affect financing of public health service provision?

In an endeavour to conduct an empirical analysis of these questions; questionnaires were used to collect data on factors influencing financing of public health service provision in Kenya, challenges faced by Ministry of Health in financing public health service provision and whether inequity in budget allocation affect financing of public health service provision.

The samples collected in the study was analyzed from the perspective of the above questions, this helped the researcher in uncovering the measures which need to be put in place and also it revealed the shortfalls in the policy on public health care financing in Kenya. Those who responded to the questionnaire also helped in uncovering the challenges faced by the Ministry of health in financing public health care provision in Kenya, it also helped the researcher to come up with recommendations of how these challenges can be resolved.

In an attempt to answer questions on the inequity in budget allocation and how it affects financing of public health service provision, the study suggested options based on opinions from the study it was discovered that several policy options which need more work to concretize interventions needs to be put in place to help in formalizing of the health care financing in Kenya.

5.2 Conclusions

The analysis suggests that:

- ❖ To eliminate the factors which affects financing of public health service provision in Kenya and to have a sustainable financial allocation, favourable economic indicators and availability of necessary infrastructures are critical prerequisites. Resources must be available, government must be in a position to afford high subsidies, the population must be

ready to pay high cost sharing, and the supply of health services must be adequate to cater for the expected rise in demand.

- ❖ For Kenya to succeed in equitable financing of public health service provision, they must increase budget allocation to Ministry of Health, they must also develop health financial plan for all Kenyans, they need to introduce these plans carefully and gradually in terms of coverage.
- ❖ Kenya compares unfavourably with countries mentioned in the analysis in terms of prerequisites for sustainability the financing of public health care provision, largely due to a poor economy, high poverty levels and shortfalls in facilities and services
- ❖ The study concludes that Kenya lacks the key prerequisites to deal with the factors affecting public health service provision pointed out in the research. Sustaining the equitable and increased budget allocation to the Ministry of Health will not be possible unless the necessary measures are put in place to deal with the challenges cited in the study. The increased budget allocation can hardly be supported by the current status of the economy and health care infrastructure.

5.3 Recommendations

This study recommends that:

- ❖ The current capacities must be improved through investor incentives (tax concessions, subsidies) to those investing in health services for example, non-profit making hospitals should be exempt from corporate taxes. It may also pay to consider subsidies to efficient and effective mission and charitable hospitals, especially where it is not cost effective for the government to run its own facilities, rehabilitation of Government facilities in terms of quality improvements, expansion, supply of equipment, drugs and personnel should be explored.
- ❖ Preventive primary health care should be enhanced, by reducing the incidences of disease occurrence, curative costs are likely to go down, hence freeing some resources for use in other areas. The Government should play a lead role alongside other partners in preventive and promotive health care programs, by increasing health budget 15% percent of

government expenditure to about 25%, also by taking the lead role towards facilitating access to safe water by all Kenyans.

- ❖ The health sector to set up an efficient system of revenue collection within appropriate duration. The system should however be flexible enough and should not be tied to households ability or insurance cover. To raise more funds for the financing of public health care provision a phased plan could be introduced to allow patients to pay the medical costs by installments. This could be facilitated through signing a memorandum of agreement with the patient/payee.

5.4 Suggestion for further study

- ❖ The study has not be exhaustive in answering all the aspects of these questions because of resource limitations and because it was not possible to conduct an exhaustive field survey. Paucity of data has also been a limitation, However, further study is suggested in the following areas:
- ❖ The potentials for extending health care financing to the informal sector in the urban areas.
- ❖ Possibility of amending existing legislations if it introduces entry barriers to the financing of public health service provision, exploring the opportunities of financing health services that do not depend directly on the exchequer or corporate financing.
- ❖ Research in the areas of developing a sustainable system for the financing of public health care provision in Kenya, such as health insurance cover for all Kenyans should be explored further.

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APPENDICIES

3.7 WORK PLAN (TIME SCHEDULE)

ACTIVITY	2007		
	September	October	November
<ul style="list-style-type: none"> • Proposal Preparation • Collection of Data 	→		
<ul style="list-style-type: none"> • Data analysis • Interpretation of Data 		↔	
<ul style="list-style-type: none"> • Compiling Research report • Submitting draft report • Submitting final report 			↔

3.8 RESEARCH BUDGET

S/No.	ACTIVITY	UNIT	QTY COST KSHS.	TOTAL KSHS.
1	Data Collection	Transport	5,000	5,000
2	Sample Analysis using SPSS software	Computer expenses	10,000	15,000
3	Stationary	- Printing papers	500/=	500
		- Flash Disk	5,000	5,000
		Photocopying and Binding	15,000	15,000
4	Labour Charges	Typing Expenses	10,000	10,000
	TOTAL COST			50,500

APPENDIX II

QUESTIONNAIRE

This questionnaire was purposely for academic work in partial fulfillment for the award of Masters Degree in Business Administration (MBA) at the Department of Business Administration, School of Business Kenyatta University. Any information given will be treated with strict confidentiality and for the purpose of this research only.

Questionnaire No.

1. Designation of the respondent?

Please tick ()

Chief Finance Officer () Director () Estimate Officer ()

Public Relations Officer () Accountant ()

Other (specify)

2. State the level of financing public health care over the past 12 months? Please tick

(a) High () (b) Low () (c) Adequate () (d) Not adequate ()

3. What health financing measures are needed to improve the sustainability and

Performance of Kenyan health systems?.....

(a) Adequate budgetary allocation from the Government ()

(b) Fees charged on services offered ()

(c) Health Financing Schemes ()

4. Do you have any other sources of financing public health care provision other than the budget allocation?

Yes () No ()

If no, briefly explain reasons

If yes, what are the sources?

User Fee () Donor Funding () Insurance covers ()

5. Are people willing to pay for health services? Yes () No ()

6. When was user fee started in the public health facilities?

7. What is the response towards user fees?

Very Good () Good () Fair () Poor ()

8. What are the strength of the Ministry of Health and Finance in financing of public health provision?

- (a) Enhanced donor funding
- (b) Increased budgetary allocation to health
- © Extending health facilities to rural areas

9. What are the challenges faced by your Ministry in Financing public health provision

- (a) Political interference
- (b) Corruption in distribution of drugs
- © Brain drain in the health sector
- (d) User fees defaulters
- (e) Inefficient health care services

10. What improvements would you like to see in the financing of public health provision in order of importance?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

11. What do you think are the factors affecting financing of public health care provision in Kenya?

- a) Corruption
- b) Budget deficit
- c) Mismanagement
- d) Infrastructure
- e) Other (Specify).....

12. List four main reasons why you think inequity in budget allocation affect financing of public health service provision

.....

13. What problems do you encounter when allocating financing resources to health care provision (list three in order of importance)?

.....

14. Suggest what would the government do to tap potential sources of finance for public health facilities? (Tick the most appropriate)

- (a) Monthly contribution by employed people
- (b) Funding from donors and private sector
- (c) Enforcing Tax levy to the rich
- (d) Charging extra fees to the health service

15. What role does quality plays in health financing measures? Please tick (What role does?)

- (a) Major
- (b) Minor
- (c) Significant
- (d) not significant

16. Have user fee revenues been used to pay for quality improvement?

Yes () No () Not sure ()

17. How do quality improvements affect costs and financing Policy?

a) High cost of health service () (b) Accessibility of health facility will be hindered ()

c) Health budget will increase(d) Other specify

18. How can the government better use their budgets to improve their people's health?

(a) Increasing the number of Dispensaries and health centers () (b) Enacting health policy that is flexible to all () (c) Buy drugs for distribution () Other specify

.....

19. Can hospital autonomy help government reduce hospitals' share of the public health Budget in favour of primary health care?

Yes () No () Not sure ()

If Yes explain how.....

.....

20. What are the main ways of sharing the risks or easing the burden of paying for health care?

(a) Enacting policy of health financing scheme for all people ()

(b) Improving health insurance scheme ()

© Increasing user fees ()

(d) Employees to increase funds for work man compensation ()

21. What political forces must be dealt with, and what strategies are most likely to succeed at national level to achieve greater equity in health?

a) Enacting laws that lead to equitable health care

b) Facilitation in implementing free health care policy

c) Enforcing Monthly contribution by everyone

d) Others specify.....

22. What impacts do debt payments, and the harsh conditions laid down for debt relief, have on public revenue and spending on the health?

(a) Deficiency in tax collection ()

(b) Poor Service Delivery ()

© Health services will not be equitably offered ()

23. How do the levels, conditions and effectiveness of Donor funding influence health equity?

(a) Low donor funding to support equity in health services ()

(b) Corruption in Ministry of Health

© Inadequate funding from the government ()

24. How would you describe the current status of public health provision financing in Kenya?

Very Good () Good () Fair () Poor ()

Other (specify)