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Equity in The Provision of Health Care: Ensuring Access of The Poor to Services Under User Fee Systems

A Case Study: Kenya

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in Kenya**

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Acronyms

| | |
|---------------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| BASICS | Building Support for Institutionalizing Child Survival |
| CDA | Community Development Assistant |
| CHAK | Christian Health Association of Kenya |
| DHMB | District Health Management Board |
| DHMT | District Health Management Team |
| KCS | Kenya Catholic Secretariat |
| KHCFP | Kenya Health Care Finance Project |
| KNH | Kenyatta National Hospital |
| MCH | Maternal/Child Health |
| MOH | Ministry of Health |
| MSH | Management Sciences for Health |
| OIC | Officer in Charge |
| STD | Sexually Transmitted Disease |
| TB | Tuberculosis |
| USAID | United States Agency for International Development |

Executive Summary

The purpose of this study was to determine whether equity of access to health services was maintained in the Kenyan health system, which used user fees. That is, whether fee waivers, the safety mechanisms introduced to ensure poor had access to health care services after the introduction of user fees, were working. The data for the study was obtained from three primary sources: household surveys of the poor, patient exit interviews at health facilities, and surveys of public and private health facilities. These sources ensured that information was obtained from not only those individuals using the health services but also those who did not show up at the health facility for care.

The Kenyan Ministry of Health, in developing its cost sharing program, had as one of its fundamental guiding principles the use of waivers and exemptions to ensure access for the poor and medically needy. Waivers are discretionary releases from payment of user fees based on inability to pay and are intended for the poor. Waivers are determined at the discretion of health workers. Exemptions are an automatic excuse from payment when it is desirable that certain health services are used (e.g., child welfare clinic services) or certain types of patients (e.g., children 5 and under or TB patients) receive health services.

The major findings of the study are:

Household surveys

The surveys were done among primarily poor households and in those households where someone had been sick in the last month.

- Only 55 percent of the poor in rural areas sought care, while 86 percent of the poor in urban areas sought care.
- Sixty percent of those who sought an alternative to using the government health facility did so due to costs or dissatisfaction with the service or both.
- A lack of knowledge about waivers for the poor was shown, with a majority of the poor indicating they must pay for services at government facilities.
- Ninety-five percent of these poor households indicated they knew of someone who recently had not sought care because of inability to pay.

Patient Exit Interviews

- On average, the poor traveled a further distance to obtain care.
- Of those using government facilities, more than half had first sought treatment elsewhere for this episode of illness.
- The poor sought care sooner than the non-poor.
- Seventy-three percent of the poor and 87 percent of the non-poor paid for their care the day of the interview.
- There was no leakage of the waiver system: 100 percent of the waivers granted the day of the surveys went to the poor. One third of the exemptions were accounted for by the poor and the remainder by the non-poor.
- The poor are more dependent on family members to assist with payment for health services (53 percent used this source to pay for their health services) and only 13 percent used their own money or savings. Fifty-two percent of the non-poor relied on their own money and savings.
- Information about waivers was usually obtained informally from health staff, friends, or relatives.

Government Health Facilities

- The waiver system does not adequately protect the poor.
- The value of waivers granted relative to all potential revenues was less than one percent.
- The emphasis on generating revenues from treatment fees resulted in high levels of undercoverage from the waiver system (i.e., when eligible poor do not receive a waiver from paying fees) and low levels of leakage (i.e., when ineligible non-poor receive a waiver).
- Health administration deliberately did not publicize the waiver system for fear of abuse.
- Records and monitoring of the waiver and exemption systems were nearly nonexistent.
- Clinical staff dealing directly with patients were not involved in the process of granting waivers, as the system was designed.
- Staff received no training in the policies and procedures for granting of waivers.
- The poor are indirectly protected, to some degree, by the subsidized services, with low level of fees relative to the costs of providing the services.

Non-Government Health Facilities

- Formal waivers did not exist, but there were mechanisms to protect those who could not pay for services, such as patient welfare funds and discharging patients who could not pay with an invoice for the charges accrued.
- Rural mission hospitals were successful in balancing the need to serve people with the need to pay the bills.
- Private urban institutions did not grant waivers except for emergencies.
- Mission facilities had "early warning systems" to alert them of patients with potential problems in paying their bill.
- Private facilities maintained good waiver record keeping and monitoring systems.
- Private facilities shifted some of the poor to government facilities.
- Undercoverage continues to exist and leakage is minimal.

The study concludes with recommendations for changes in policy, operations of the waiver and exemption systems, and improved record keeping and monitoring of waivers and exemptions.

1. Introduction

Many developing countries have a tradition of free public provision of all health services. However, as economies and government revenues have seen severe downturns in many of these countries in the last decade, the need for additional sources of revenue to operate the public sector health system and its services has become more acute. The result has been increased interest and implementation of cost recovery schemes. As noted by Gilson and Russell in "Cost Recovery in Government Health Services — Is Equity Being Considered: An International Survey," the policy debate has shifted from the issue of whether to introduce cost recovery to how such systems should be introduced. Many cost recovery systems have been designed with the sole or primary objective of generating revenues to replace or supplement government funds. In designing such systems, often little consideration was given to the anticipated impact from introducing user fees. As the introduction of such schemes have become more widespread and some of the unintended effects observed, a concern has developed about the equity implications. How have cost recovery systems affected the access to and utilization of health services for the poor and other vulnerable groups? These concerns are based on the belief that health care is a basic right and its receipt should be based more on need than one's ability to pay.

The result of these concerns has been the development of various mechanisms designed to protect the poor from the effects of user charges. These protection mechanisms have various forms and terms: means testing, direct targeting, characteristic targeting, and waiver and fee exemption systems. These systems are designed to ensure that cost recovery efforts do not create serious financial barriers for the poor or other groups, such as those with certain illnesses, which would unduly reduce their access to care. It is these concerns that caused Health and Human Resource Analysis for Africa (HHRAA) of the USAID Africa Bureau to seek a more formal evaluation of the equity implications of cost recovery schemes, review which systems meant work the best to maintain equity and develop a series of options for policy makers. To do this, HHRAA proposed development of a methodology, use of the methodology to carry out five country case studies, synthesis of the lessons learned from the country case studies, and provision of guidance and options for future policy development for other countries based on the results.

The case studies are to be a practical source of information that can be used immediately by the ministry of health and AID mission of the host country in assessing its existing exemption systems. Kenya was asked to be one of the country case studies because of its well developed cost sharing program. Each case study also provides a basis for making cross-national comparisons and learning about successful mechanisms that ensure equity under a user fee system.

This report first reviews the objectives of the study, describes the targeting mechanisms used in other sectors in Kenya, outlines the Kenyan waiver and exemption mechanisms in the health care sector, presents the methodology of this study, reports the study's findings, and finally presents some conclusions and recommendations for consideration by the Government of Kenya.

2. Objectives of the Study

Kenya, as other countries that have introduced cost sharing programs, has faced one dominant question since the expansion of user fees: how effective are the safety mechanisms, namely fee waivers and exemptions, in protecting the access by the poor to health services? To assess this issue of achieving equity under cost recovery, it agreed to serve as one of the five country case studies. The Government Health Care Financing Secretariat and USAID saw this as an opportunity to obtain an evaluation of its waiver and exemption systems. It also sought to have a review of waiver systems in non-government institutions in case there might be lessons to be learned from the private sector. Thus Kenya not only is contributing to the international study on equity and user charges, but also would benefit directly from the findings of the case study research.

The purposes of conducting this study are summarized by these basic questions: Are the poor who visit health facilities receiving waivers from paying fees? Are there poor who are eligible for waivers who do not receive waivers? If so, do these people receive care and from which providers? Are non-poor receiving waivers for which they are not eligible?

The purpose of this study is to answer those questions. The specific study objectives are:

- To review and contrast public and private sector waiver systems;
- To assess the effectiveness of waiver (means testing) and exemption systems;
- To estimate the costs of these safety mechanisms; and
- To make recommendations for policy changes for the national cost sharing program.

Effectiveness of the waiver and exemption systems will be evaluated in three ways:

- (1) effectiveness of identifying and granting waivers to those truly poor who come for care;
- (2) the effectiveness of the system in not granting waivers to the non-poor who come for care; and
- (3) effectiveness of reaching those poor who do not come to the health facility.

3. The Study Approach¹

The study was designed to gather data for two purposes: to provide descriptive information on the waiver and exemption systems and to enable an assessment of the effectiveness of the waivers and exemptions. The descriptive information relates primarily to the operational issues of the system. It provides data about how the system works, the actual waivers and exemptions granted, and experiences of the poor, non-poor, and exempt patients in using the system for those who were accessing health services. The assessment process evaluates the effectiveness of the systems in achieving equity.

As outlined in the methodology, there are four basic outcomes with waivers targeted for the poor. Two are appropriate: the poor receive a waiver from paying fees and the non-poor do not receive a waiver from paying the user charges. Two other outcomes are inappropriate: the poor who are eligible do not receive a waiver from paying fees and the non-poor who are not eligible for a waiver do receive a waiver. These inappropriate outcomes are referred to as undercoverage and leakage, respectively.

Undercoverage and leakage are measures of the ineffectiveness of waiver systems designed to protect the poor. Attaining data on appropriate use of waivers and leakage required gathering information from patients and staff at hospitals and health centers. Gathering data on undercoverage required obtaining information from households that had not presented at the health facility for care. These were people who either had not used the available health services due to the fees charged, even though they were eligible for fee waivers, or people who had elected to use other health providers or facilities. This latter group may have been the poor who could not pay fees or those who could pay but elected to use alternative facilities or providers.

Thus, to determine the waiver system's effectiveness in providing access to health services for the poor while minimizing the number of non-poor who are provided waivers, the study had to obtain information about patients, poor and non-poor, who receive treatment at health facilities, as well as those poor who are not receiving services at health facilities. Meeting the study objectives of evaluating effectiveness required that data be gathered to evaluate the impact of the waiver and exemption system on two groups: those receiving care and those not receiving care. Hence, the basic sources of data gathered and analyzed were:

- information and data available at health facilities
 - health facility administrative staff interviews
 - health facility clinical staff interviews

¹ The basic methodology for this study was prepared for BASICS and reviewed by a Technical Advisory Group. It is available from the document "Methodology for Equity and Coverage of Health Care Provision Study" by William Newbrander and David Collins, Management Sciences for Health, April 1995. It was prepared for the BASICS Project and supported by the Health and Human Resource Analysis for Africa, USAID Africa Bureau. The design for this particular country study was adapted from the methodological guidelines by the study team and the KHCF Project to fit the circumstances of Kenya so it was relevant to the needs of the Ministry of Health while also meeting the overall study objectives for the multi-country study. Field work for the case study was undertaken collaboratively with two research partners: Mr. Moses Njau of the Department of Health Management of Moi University, Eldoret, Kenya, and Ms. Clarice Auma of the STD Division of the Ministry of Health, who has experience in conducting household surveys and patient exit interviews with the MOH's Kenya Health Care Financing Project.

- health facility patient interviews
- review of health facility records

- information and data available only from household interviews
 - interviews with those poor not presenting at health facilities to learn of their ability to access the system through waivers and their choice of health care providers.

Details on the information gathered from each of these data sources is presented below.

3.1 Health facility information

The data gathered from health facilities were quantitative and qualitative. Quantitative data were obtained by examining records of the health facilities to determine how many waivers and exemptions were granted and the value of such waivers. Qualitative information was obtained to supplement and corroborate the quantitative data obtained by interviewing staff and patients. The following information was gathered at health facilities:

Health facility administration: Structured interviews with the hospital or health center administration — such as the medical superintendent, hospital secretary, hospital matron, officer in charge, and administrator — were held at each health facility. The interviews gathered information on the community and catchment area of the health facility; types of services provided; the fee structure for those services; policies and procedures for granting waivers and exemptions; systems in place for the waivers and exemptions; and information about waivers and exemptions provided to the facility's patients, staff, and community. Data was also gathered from records of the facility on the number of waivers and exemptions granted, the value of those waivers and exemptions, and the total volume and revenues of the facility.

Health facility staff: At each facility, structured interviews were also held with the hospital or health center staff who would implement the waiver and exemption policies. The staff involved with the waiver and exemption process who were interviewed included the inpatient ward and outpatient clinic matrons and nurses; clinical officers; social workers; staff in service areas that charge fees, including pharmacy, laboratory, and radiology; and staff in the accounts or revenue departments of the facility. The interviews gathered information on the fee system, how the waivers and exemptions were granted, and the role the staff had in initiating, recommending, and approving individual patients for waivers. Staff was also questioned about any training they had received concerning waivers and exemptions, as well as information they provided to patients they were serving. Quantitative data was obtained from the ward and clinic ledger records on patients who were granted waivers and exemptions. This information was used to corroborate the implementation practices on the facility's waiver and exemption policies specified by the administrative staff.

3.2 Patient exit interviews

To substantiate how the system works in practice, it was necessary to gather information on the users' experiences and knowledge of the waiver and exemption system. Patient exit interviews were held in the outpatient clinics and on the inpatient wards, with both poor and non-poor patients. The information obtained included the distance patients had traveled to receive care; how long they had waited after the

onset of illness before seeking care; whether they had paid for services and how much; what their total bill was; what their source of money was for paying for care; and their use of waivers and exemptions. The interviews also obtained data about their knowledge of the waiver and exemption system, how people were excused from payment, and how they obtained the information they had about the system, even if they had not used it themselves or were non-poor. Patients were also asked about other people's experiences in seeking care and the reasons for any access barriers they might have experienced.

3.3 Household survey information

The above data provided information about how the system worked, the actual waivers and exemptions granted, and experiences in using the system for those who were accessing health services. The other key issue of effectiveness of waiver systems is to know about the poor who are not using health services at the sampled facilities. To gather this information, poor households in the communities around some of the health facilities surveyed were interviewed.

The household survey samples were purposive — they sought to maximize the number of poor households interviewed to learn the effectiveness of the waiver system. The first step at each site surveyed was to identify the neighborhoods around the health facility where many poor lived and conduct the survey there. This maximized the number of poor households surveyed. Second, because there was an interest in learning about use or non-use of health services by the poor, only those households where someone had experienced an illness in the last month were surveyed. All household interviews were held with an adult. Respondents were asked if a health provider was sought for the episode of illness, and if so, where did they go for care. If they did not seek care, or sought care at some provider other than the nearest government or mission health facility, they were asked the reason for their particular choice. The survey also assessed the household's knowledge and experiences in using and accessing the waiver and exemption systems, the source of that knowledge, their knowledge of the experiences of other people in seeking care, and the reasons for any access barriers they may have experienced.

3.4 The sample

Ten health facilities, listed in Table 1, were sampled for this study. They represent a variety of characteristics: urban and rural facilities; various facility types, including health centers and tertiary, provincial, and district hospitals; and government and private, mission facilities. All facilities sampled were non-profit institutions. As the multi-country basic methodology framework specified, it was felt that for-profit hospitals provided very few waivers and thus their experiences were of minimal interest.

Table 1: Health Facilities Sampled and Their Setting

| | Government | Non-Government | Urban or peri-urban | Rural | Hospital | Health Center |
|--|----------------|----------------|---------------------|----------------|----------------|----------------|
| Kenyatta National Hospital | XX | | XX | | XX | |
| New Nyanza Provincial General Hospital | XX | | XX | | XX | |
| Homa Bay District Hospital | XX | | | XX | XX | |
| Kendu Bay Health Center | XX | | | XX | | XX |
| Pap Onditi Health Center | XX | | | XX | | XX |
| Kendu Adventist Hospital | | XX | | XX | XX | |
| Tenwyk (Baptist) Hospital | | XX | | XX | XX | |
| Mater (Catholic) Hospital | | XX | XX | | XX | |
| Aga Khan Hospital | | XX | XX | | XX | |
| Kikuyu (Presbyterian) Hospital | | XX | XX | | XX | |
| TOTALS and Percentages | 5 (50%) | 5 (50%) | 5 (50%) | 5 (50%) | 8 (80%) | 2 (20%) |

The study's time frame limited the size of the sample, and the primary questions of interest of this study related to issues primarily concerning the poor. Information about areas of the community where the most poor households were located was obtained locally. National research surveyors were used to make a subjective assessment as to whether a patient or household was poor. Observed factors — such as the appearance and value of the home, property in and outside the home (e.g., livestock), educational levels and enrollment of children in school, clothes, shoes, and dress and appearance of relatives — were used to make the assessment of whether a patient or household was poor.

The household interviews were done only in rural and peri-urban areas, not in large urban areas. This was because the catchment areas were more easily defined in rural and peri-urban areas and the choices for care were easily identified. This was important since the information sought was the health seeking behavior of the poor.

The findings from these health facility surveys and household interviews are presented below, followed by some conclusions and recommendations.

4. Description of Exemptions and Waivers in the Health Sector in Kenya

Kenya has had nominal user fees for health services since independence in 1964. This cost sharing system was expanded in December 1989 to include higher fees and broaden the types of services for which fees were charged. A brief suspension of outpatient fees in September 1990 was followed by the phased strengthening of cost sharing the following year. With the cost sharing scheme, a system of waivers also was developed so the poor would continue to have access to health services. A fuller description of these fee systems may be found in the work by Quick and Collins. In addition, certain categories of patients were exempted from payment of fees (see Annex 3). A more extensive description of the historical and operational elements of the fee systems may be found in "Impact of Cost Sharing in Kenya: 1989-1993" and Health Financing Reform in Kenya: The Fall and Rise of Cost Sharing 1989-1994.

4.1 Definitions

Waivers are intended for the poor. They are *discretionary releases from payment based upon inability to pay*. Waivers are determined at the discretion of health workers.

Exemptions are an *automatic excuse* from payment. Exemptions are granted when it is desirable that certain health services are used (e.g. child welfare clinic services) or certain types of patients receive health services (e.g. children five and under or TB patients). This term is synonymous with "characteristic targeting," that is, targeting people with certain characteristics in order to encourage them to use certain health services. Exemptions may be granted for a variety of reasons, as listed below.

4.2 Current fee structure

The current fees at different types of health facilities are shown in Table 2 for comparison purposes. The private hospital fees shown are from a rural mission hospital and are indicative of the fee levels at these institutions, while the private urban hospital is a private hospital. For comparison purposes, a bottle of Coca-Cola costs from KSh. 8 to 10. The average daily wage ranges from approximately KSh. 49 per day for an unskilled laborer to KSh. 75 per day for a basic clerk or secretary. The circular detailing "User Fees at Ministry of Health Institutions" is provided in Appendix B.

Table 2: Typical Patient Fees at Public and Private Health Facilities

| Type of Health Facility | Outpatient treatment fee | OP Consultation (specialist) fee | FP, antenatal, child welfare clinic | Laboratory fee ^a | Inpatient daily charge | Delivery fee | Amenity/Private ward |
|---|--------------------------|----------------------------------|-------------------------------------|-----------------------------|--------------------------------------|--------------|-----------------------------------|
| Government health center | 10 | N.A. | 0 | 20/40/60 | 10 | 40 | N.A. |
| Government district and sub-district hospital | 20 | 20 | 0 | 20/40/60 | 30 | 80 | 400 |
| Government provincial hospital | 30 | 30 | 0 | 20/40/60 | 40 | 100 | 400 |
| Kenyatta National Hospital | 20/40/50 | 100 | 0 | 30 - 72 | 100 | 700 | 100 |
| Private NGO hospital rural (average) | 70 | 650 | 5 | 70/100-150/ 250-550 | 230 ^b | 3,000 | 230 |
| Private hospital, urban | 300 | 1,100 | | | 3,000 to 5,000 plus doctor fee | 2,625 | 4,700 to 6,700 plus doctor fee |

^a These are for simple, intermediate and specialized laboratory tests, respectively.

^b Plus an admission charge of KSh 100.

4.3 Current mechanisms to protect the poor

A number of direct and indirect mechanisms to shield the poor from the full impact of the fees exist. The direct mechanisms are those that are aimed directly at the poor. These are exemptions from paying fees. The indirect mechanisms are those which were not specifically designed for the poor but give them some protection from the potential impact of full fees.

4.3.1 Direct protection mechanisms: waivers

Waivers are granted to the poor at government facilities by the health worker at the point of service, such as the ward nurse or the charge nurse in the outpatient clinic. This occurs by having this staff member recommending a waiver by filling out a standard MOH form. The waiver form is forwarded to the medical superintendent or his designated officer for his or her approval. If granted, that patient is exempted from treatment fees, ancillary services fees and drug costs for that particular episode of illness. This was the general system in all the government facilities. There were variations, such as a provincial hospital where the medical superintendent had appointed a staff member to be in charge of the waiver system and had delegated authority to that staff member to review all waiver applications and approve or deny the application. Private hospitals had no formal waiver system, as explained in section 6.2.

4.3.2 Indirect protection mechanisms: exemptions, free services and subsidized services, and unofficial mechanisms

It is not only exemptions that indirectly benefit the poor, but also fee limits and subsidies listed below. Though none of these is specifically targeted at the poor, both the poor and non-poor benefit by not having to pay fees or paying fees that are substantially less than actual costs. While some may argue these fee structures are regressive because they are not based on ability to pay, they benefit the poor as well as the non-poor.

Exemptions

There are four types of exemptions: exempt patients, exempt outpatient services, exempt illnesses, and exempt inpatient services. Exemption is based on the individual characteristics of the patient or types of health problems. A copy of the "Exemption Rules for Ministry of Health Institutions" is provided in Appendix C. These are health problems or services that qualify for being excused from paying fees at government facilities.

- Exempt patients
 - children under five years of age (for outpatient fees only)
 - unemployed
 - prisoners

- Exempt illnesses
 - tuberculosis
 - leprosy
 - antenatal complications from pregnancy
 - AIDS

- Exempt outpatient services
 - child health or welfare clinics
 - antenatal and postnatal clinics
 - family planning visits
 - sexually transmitted disease clinics
- Exempt inpatient services
 - After 14 days of inpatient care, patients are exempt from further charges (this applies only to ward fees not laboratory or x-ray fees)
 - Downward inpatient referrals from higher to lower level facilities
 - Upward inpatient referrals from lower to higher level facilities; time spent in lower level facilities count toward the 14 day maximum inpatient charge limit; exemptions do not apply for referrals to the national tertiary hospital, Kenyatta National Hospital

Until recently, health workers, civil servants, and children between the ages of five and 14 were also exempted from charges at government health facilities. Eligibility for an exemption is determined at point of service and requires no formal process. The exemption for outpatient visits applies to treatment, x-ray, and laboratory fees.

Free services and subsidized services

- Services at all dispensaries are free.
- Inpatient services are heavily subsidized. The current inpatient daily fee at a district hospital is KSh. 20 per day plus laboratory and x-ray test fees, which range from KSh. 20 to 60 per test, plus any surgery fees, which are KSh. 100 for major surgery. Hence a ten day stay would cost, on average, KSh. 60 per day or KSh. 600 for the total hospitalization. The cost study of hospitals for the National Hospital Insurance Fund found the actual cost, on average, to be KSh. 300 per day for ward and all other fees or KSh. 3,000 total for a ten day stay. Thus fees at government facilities represent a 80 percent subsidy of actual costs of providing those services: average charges of KSh. 60 per day for services costing KSh. 300 per day.
- Outpatient services are also subsidized at all levels in that the fees are substantially less than the actual costs of providing services.
- Graduated outpatient service fees are lower at the lower service levels of the system. The outpatient treatment fee at health centers is KSh. 10, KSh. 20 at district hospitals and sub-district hospitals, and KSh. 30 at provincial general hospitals.
- There are no fees for return visits for follow-up treatment within 14 days for the same episode.
- There are no fee charges for patients who are referred up from other facilities. This is designed to reinforce the appropriate referral system for seeking treatment at the lowest level possible.
- The fees are "flat fees," that is services or drugs that are more expensive have the same price as those drugs or services that are less costly. This eliminates any access problems to necessary expensive drugs.
- Inpatient charges are capped at 14 days. The maximum days for which the daily charge is made for inpatient services is 14 days. After that, continued hospitalization is provided at no inpatient charge to the patient.

Unofficial mechanisms: abscondment

Many inpatients leave the hospital unofficially before discharge by absconding. This is another mechanism by which patients, including the poor, do not pay fees for inpatient treatment. This was a

serious issue at both public and private hospitals. Often the known or suspected reason for abscondment was the patients' fear of not being discharged because they were unable or did not desire to pay the hospital fees. While nearly 30 percent of patients at government facilities may abscond, it is estimated that only one quarter of them are eligible for a waiver as a poor person.

4.4 Summary

The circular from the MOH Health Care Financing Secretariat in August 1994 that officially increased the various fees at government facilities stated:

You are reminded that no Kenyan should be denied access to medical care at a Government hospital because of his/her inability to pay and that in order to protect cases of financial hardship you should have a working waiver system in place.

In reality, as is indicated in the study's findings in Section 6, very few patients actually receive waivers which are intended to protect the poor. However, many of the poor are covered by direct exemptions and indirect methods of fee levels being heavily subsidized. Poor and non-poor patients are also protected against catastrophic financial loss through the 14 day cap on the chargeable inpatient days. The graduated fee structure also provides some protection as lower tiered facilities have lower fee levels with dispensaries having no fees.

5. Experiences with Waivers: Findings from Household Survey Interviews

To ascertain if there were poor who were not presenting at the health facility, and their experience with obtaining care and waivers, household interviews were conducted in communities near three of the health facilities surveyed. Two of the areas surveyed were rural and one was in an urban setting. The sample was purposive, in that poor households which had had a household member sick within the past month were sought out. At each location, communities with a predominant number of poor households were sought out to maximize the number of poor households interviewed. The first question put to the person in the household was whether anyone in the household had been sick in the last month. If the response was negative, the household was not included in the sample but the interviewer went on to the next house. This purposive sample of poor households with a sick person was desired because the experiences of the poor in obtaining waivers and their health seeking behavior were the questions of interest.

Whether a household was considered poor was based on the assessment of the interviewer. The judgment to classify the household as poor or non-poor, was based on several factors: appearance of living quarters or home, property (land, cattle, crops, other), educational level of household members, number of children enrolled in school, or clothes and shoes worn. A total of 39 households were interviewed, 13 at each of the three sites. Thirty-six of the 39 households interviewed, or 92 percent, were poor. This high percentage was expected since the survey sample was not random: the surveyors were seeking out those poor households that should be eligible for waivers to learn of their experience and utilization of health services.

5.1 Characteristics of household interviewees

Of the 39 households interviewed, all but three, 92 percent, were classified as poor. Over half (59 percent) of the households were in rural areas and the remaining 41 percent in urban areas. Of the poor, 61 percent were in rural areas.

5.2 Seeking care

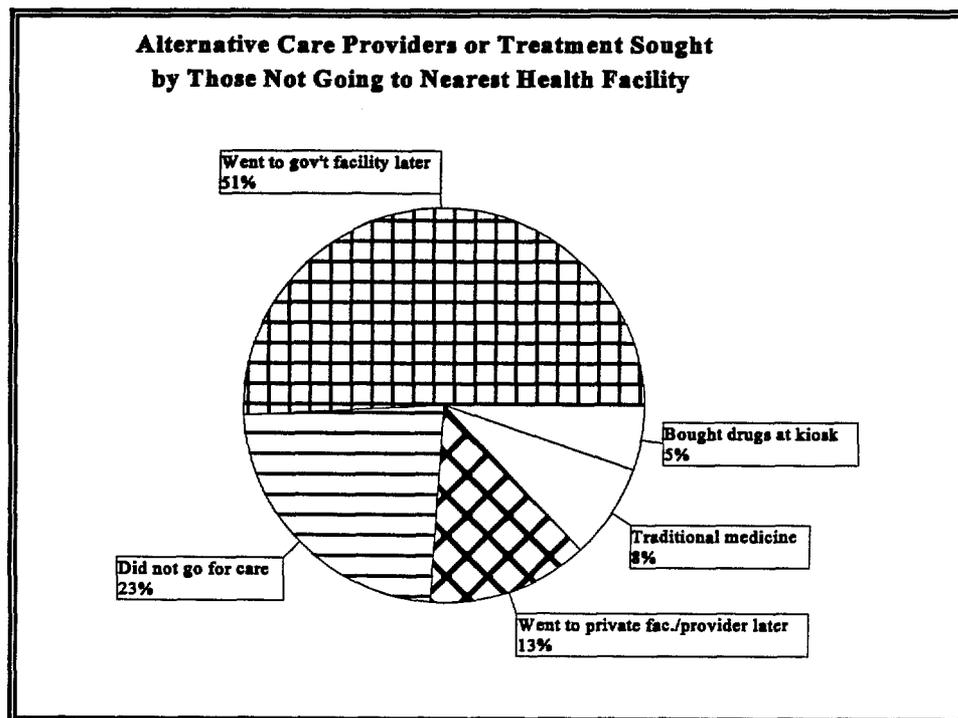
Due to the prescreening of those in this purposive sample, all the households had someone who had been sick in the last month. Sixty-nine percent of these households sought care.

Of the poor seeking care, half were from urban areas and 50 percent were in rural areas. Of all the respondents in rural areas who were poor and sick, 55 percent sought care; 86 percent of the poor and sick in urban areas sought care. Of those not seeking care, 65 percent were from rural areas. Thus there was a greater propensity for the poor in urban areas to seek care than the poor, sick of rural areas. This may be due to the urban areas having more facilities and the facilities being closer to the sick person's home than the proximity of location and number of facilities the rural people have available from which to choose.

5.3 Alternatives for seeking care

The respondents who did not seek care immediately were asked what they had done for the condition of the sick household member. As shown in Figure 1, nearly a quarter never sought care. Half of the respondents later sought care at a government facility, indicating that government facilities are often the only available sources of care for rural populations.

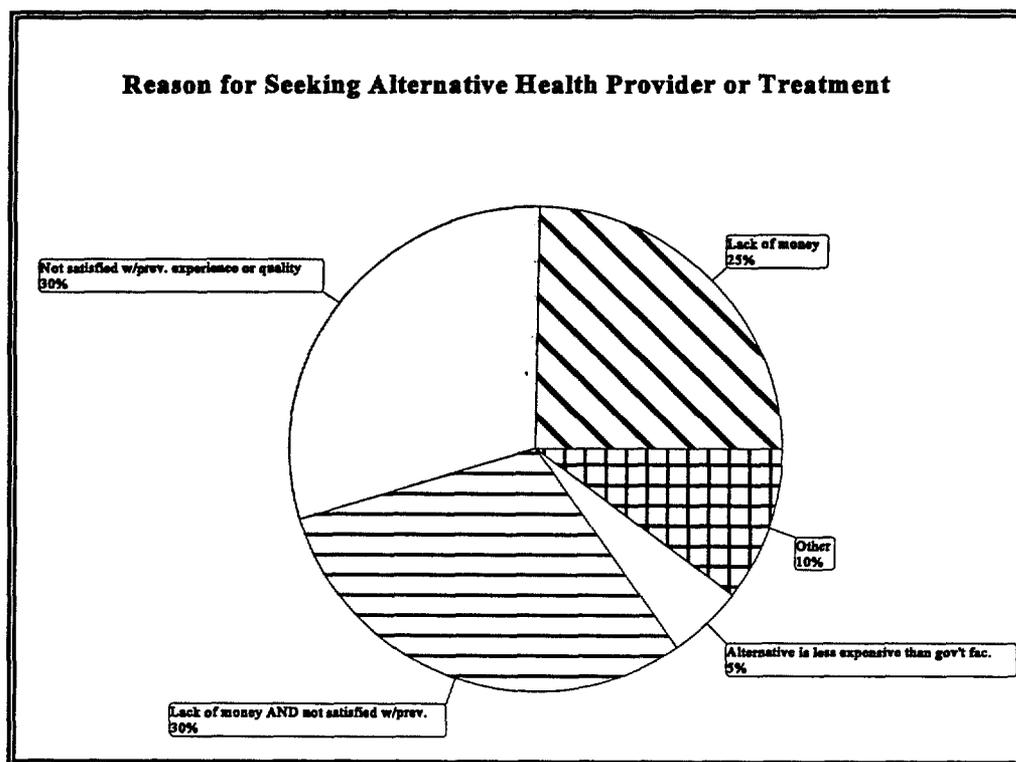
Figure 1



5.4 Why people use other health providers or facilities

Those who sought out alternative providers or treatment were asked the reason or reasons for this. As shown in Figure 2, finances was the reason, in whole or in part, for 60 percent of the respondents seeking alternatives: those seeking less costly care, lack of money, or combination of lack of money and dissatisfaction. Quality is raised as an issue by the poor at this point. The response of "Not satisfied with previous experiences" accounts for 60 percent of the responses. This may be due to clinical quality concerns or dissatisfaction with the interpersonal aspects of quality from the patient and provider interacting.

Figure 2



5.5 Knowledge about waivers

To determine the knowledge of the poor households about waivers, they were asked "Do the poor pay for care or receive waivers?" The results were:

- 69 percent of all households said the poor do pay.
- 72 percent of the poor said that the poor must pay, while only 33 percent of the non-poor said so.
- 87 percent of rural interviewees and 49 percent of urban respondents said the poor must pay.

Urban residents appear to be more aware of waivers: 86 percent of rural poor said the poor pay, while only 50 percent of urban poor said the same. Of the poor respondents who said the poor must pay for care at government facilities, 73 percent were from rural areas and 27 percent from urban areas. These perceptions were validated by the interviews with the health staff, which indicated that the facilities gave very few waivers. Thus, the responses of the poor may well be grounded in experiences of not receiving waivers at the health facilities.

Households that responded that the poor did not have to pay were asked the sources of their information about waivers: How did you learn the poor do not have to pay? Health staff accounted for 56 percent of the sources of knowledge, and families or friends were the primary information source for 10 percent of the respondents.

5.6 Knowledge about exemptions

Interviewees were also asked about their knowledge of exemptions. Table 3 indicates the proportion who stated that the following categories of patients or diseases were exempted. Note the differences in responses between the rural group and the overall sample. Ten percent of people learned of exemptions from friends or relatives.

Table 1: Interviewees Knowing the Categories of Patients Exempted from Fees

| | All | Rural |
|---------------------|-----|-------|
| Children under 5 | 56% | 26% |
| Child health clinic | 56% | 26% |
| Family planning | 54% | 22% |
| Antenatal clinics | 54% | 22% |
| TB patients | 10% | 4% |
| Leprosy patients | 3% | 0% |
| AIDS patients | 5% | 0% |
| STD patients | 3% | 0% |

Eighteen percent of all respondents and 30 percent of rural respondents were misinformed and thought all children under 18 were still exempted from fees. This exemption group was changed to include only children five years of age and under.

5.7 Knowledge of others not receiving care

Nearly all households, 95 percent, most of which were poor, stated they knew someone who did not seek care because the person could not pay for it. This would be an unvalidated indication of further undercoverage of the poor with the existing waiver system.

6. Experiences with Waivers: Findings from Patient Exit Interviews

6.1 Characteristics of interviewees

Patient exit interviews were conducted with 90 patients at eight facilities. Three of the interviews were excluded from the analysis because of incomplete data. The division of interviewees into the discrete categories of poor and non-poor was based on the interviewer's subjective assessment, so it is not an absolute standard. Consequently, analyses examining those categorized as poor must be viewed cautiously. The interviewer sought to have at least half the patients interviewed be poor: in reality, 74 percent of those interviewed were poor. As the sample was selected by the interviewer, it is not necessarily a purely representative sample. The interviewers sought to obtain respondents from a cross-section of the hospital's wards and outpatient clinics.

Of those interviewed, 53 percent were patients at government facilities and 47 percent at private facilities. Sixty-nine percent of the interviews were conducted with patients at rural health facilities and 31 percent at urban facilities. All interviews at private facilities were in rural areas as the two private hospitals surveyed in the urban area would not let the study team interview their patients.

Nearly half (48 percent) of the interviewees were inpatients. Of the inpatient and outpatient interviews, 76 percent and 72 percent were poor, respectively. Of all the poor interviewed, half were inpatients.

6.2 Distance to seek care

An important element of access is proximity to health facilities. The interviewees were asked how far they had traveled to come to the health facility. Figure 3 depicts the findings according to different groupings of the respondents. In general, the poor traveled longer distances to receive care than the non-poor. Inpatients in both public and private facilities traveled farther than outpatients. Patients at urban facilities had traveled further than those at rural facilities. Interestingly, patients being treated at government facilities had traveled further than those at the private facilities. The poor patients at urban facilities traveled further than the poor at rural facilities. This is accounted for in part because many of the poor at the urban facilities were referred patients who thus had traveled a long distance to receive care at that particular urban facility. Table 2 is provided below because it includes the median distance because of the influence of some outliers on the mean.

Figure 3

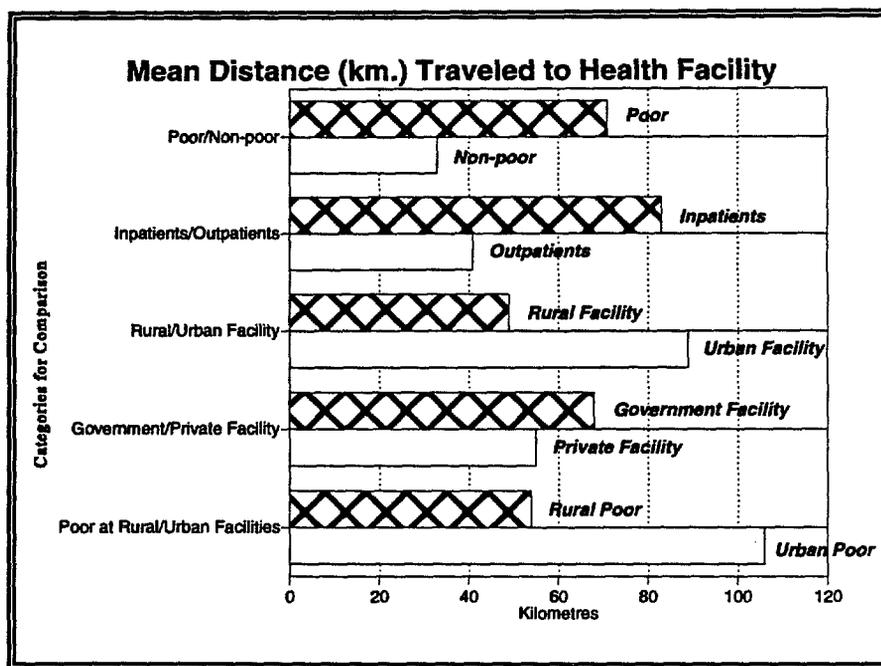


Table 4: Mean and Median Distance Traveled to the Health Facility

| | Mean Distance (Kms) | Median Distance (Kms) |
|------------------------|---------------------|-----------------------|
| Poor | 71 | 30 |
| Non-poor | 33 | 30 |
| Inpatients | 83 | 35 |
| Outpatients | 41 | 20 |
| Rural facility | 49 | 30 |
| Urban facility | 89 | 30 |
| Public/Government | 68 | 30 |
| Private | 55 | 35 |
| Poor at rural facility | 54 | 30 |
| Poor at urban facility | 106 | 30 |

6.3 Alternative health providers or facilities

Of those interviewed, 61 percent had used other health providers before seeking care at the facility where the interview took place. Of these individuals, 44 percent were now at a government facility and 56 percent were at a private facility. Of those interviewees at government facilities, 51 percent had been elsewhere for treatment for this particular illness episode before coming to the government facility. For those interviewed at private facilities, 71 percent had been elsewhere for treatment before seeking treatment at the facility where they were interviewed.

6.4 Waiting to seek care

Patients were asked, "How long did you wait before seeking care for this episode of illness?" The results are shown in Figure 4 and Table 3. Surprisingly, the poor exhibited a greater propensity to seek care immediately than the non-poor. Possible explanations for this surprising finding are: (1) the poor delay care until it is urgent, so those interviewed were sicker and needed immediate treatment because of previous delays in receiving treatment; or (2) the poor may not have the same level of health knowledge and thus do not have the information for self treatment of minor conditions. The survey did not provide any information on the patients' actual clinical conditions, so it is not possible to know if these are plausible explanations.

The difference shown in the last two columns of Table 3 between the care-seeking behavior of the poor at public versus private facilities may indicate that patients wait longer to go to private facilities, since fees are higher at the private facilities. It also seems to indicate that poverty is not influencing demand as much as was anticipated, since nearly 20 percent of the poor had sought care immediately. Price seems not to be a factor for the poor when seeking care, as compared to the non-poor. This finding may also indicate the urgency of their health situation.

Figure 4

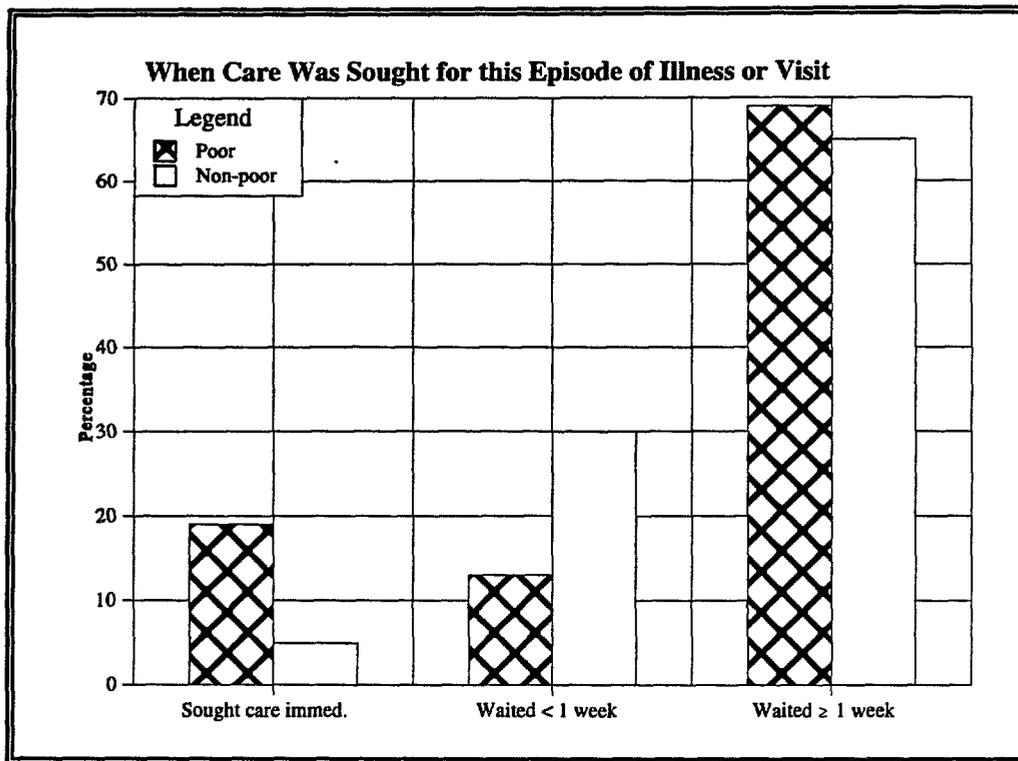


Table 3: When Care Was Sought for this Episode of Illness or Visit

| | TOTAL | Poor | Non-poor | Poor at government facility | Poor at private facility |
|---------------------------|-------|------|----------|-----------------------------|--------------------------|
| Sought care immediately | 15% | 19% | 5% | 18% | 20% |
| Waited less than one week | 17% | 13% | 30% | 21% | 3% |
| Waited one week or more | 68% | 69% | 65% | 62% | 77% |

6.5 How much did the patient pay for care?

Interviewees were asked how much they were asked to pay for care, as well as how much they actually did pay for it. Seventy-seven percent of all interviewees paid for care; thus 23 percent did not pay anything for care received that day. As Figure 5 indicates, 73 percent of the poor paid for care, compared with 87 percent of the non-poor interviewees.

Paying for care meant payment in full or a partial payment. Of all those interviewees who paid for care, 49 percent made only partial payments. For inpatients, the partial payment was usually the deposit they had made upon admission. A partial payment does not mean the remainder was waived, but that in most cases the patient had received credit and would have to pay the balance later.

Of the poor who did pay for care, 45 percent paid the charges in full while 55 percent made partial payments. This compares to 65 percent of non-poor who made full payment and 35 percent who made partial payment.

Figure 5

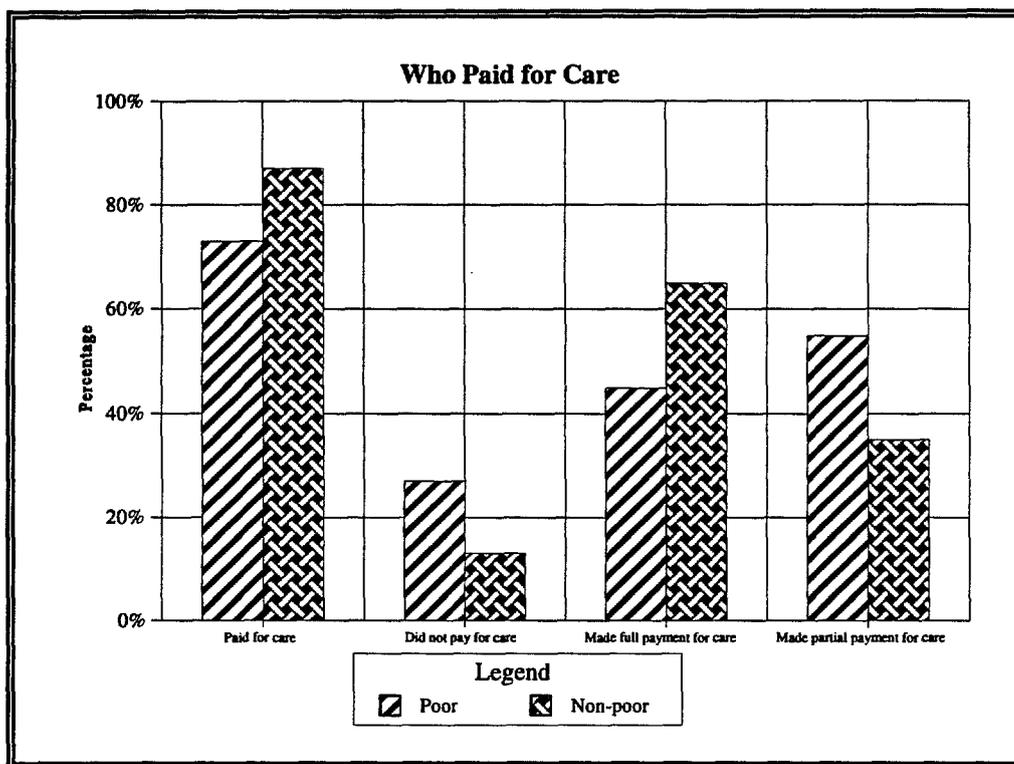


Table 4 below indicates the amounts of payments actually made by patients. Some of these were partial payments and others full payments for services rendered. The difference between the mean and median is skewed by the high cost of inpatient charges. The poor had lower payments than the non-poor. This may reflect that hospital staff, knowing which patients are poor, may not provide as many services. Whether the services provided are clinically necessary or unnecessary is unknown.

Table 6: The Amount of Payments Made for Care the Day of the Interview

| | Mean Payment (KSh.) | Median Payment (KSh.) |
|--------------------------------------|--------------------------------|--------------------------------------|
| Poor | 681 | 100 |
| Non-poor | 946 | 300 |
| Government facilities | 414 | 25 |
| Non-government facilities | 1129 | 421 |
| Poor at government facilities | 446 | 20 |
| Poor at private facilities | 948 | 340 |
| Non-Poor at government facilities | 328 | 60 |
| Non-Poor at private facilities | 1620 | 600 |

6.6 Waivers and exemptions

Only nineteen, or 23 percent, of those interviewed did not pay for the health services received the day of the interview. Figure 6 shows the reasons for non-payment. The most common reason was due to granting of a waiver. Of the waivers granted to interviewees, 100 percent went to the poor. Of the exemptions granted — all at government facilities — the poor accounted for 33 percent and the non-poor for 67 percent. Unfortunately, a shortage of drugs was noted at the government facilities; this lack accounted for a quarter of the patients who did not pay fees.

The surprising percentage of waivers as a proportion of all patients who did not pay may be a result of two causes: (1) the study sample was skewed to the poor, so one would expect a greater number of waivers for this group; and (2) the research team was not at the health facilities on child health clinic or antenatal clinic days, which account for many exemptions, and thus the number of exemptions would be under-represented.

6.7 Where do patients obtain their money to pay for care?

The source of money that patients used to pay for services is shown in Figure 7. This indicates the heavy reliance by patients on their own money, savings, or their family's financial resources: 71 percent of the paying patients relied on funds from these sources. In contrasting the poor and non-poor, the only significant difference between the group patterns, as compared to the overall pattern, was that 35 percent and 17 percent of the non-poor used their own money or savings respectively as compared to only eight

percent of the poor using their own money and 5 percent using savings. Thus the poor, without their own resources, are more dependent on family members to assist with payment for health.

Figure 6

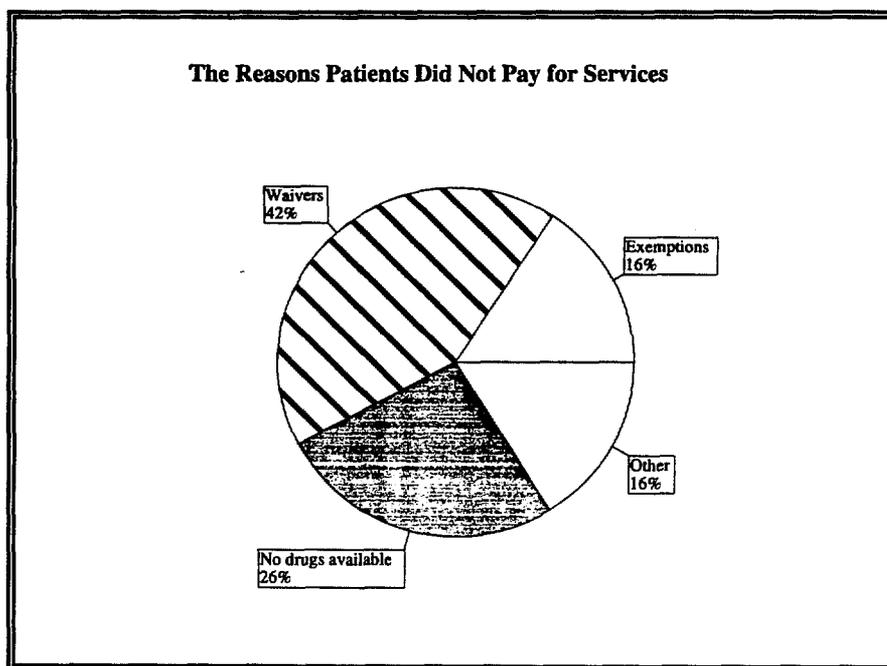
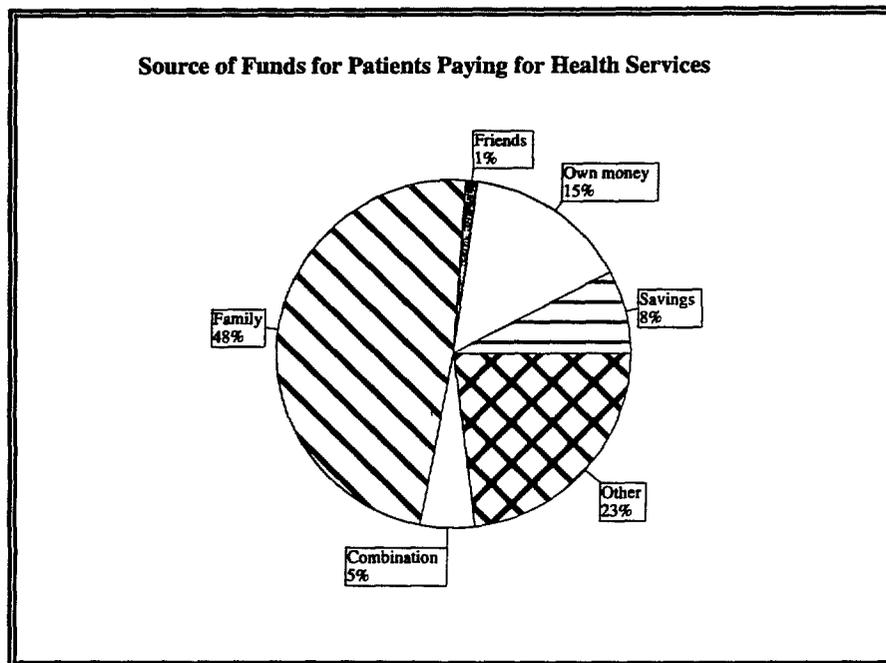


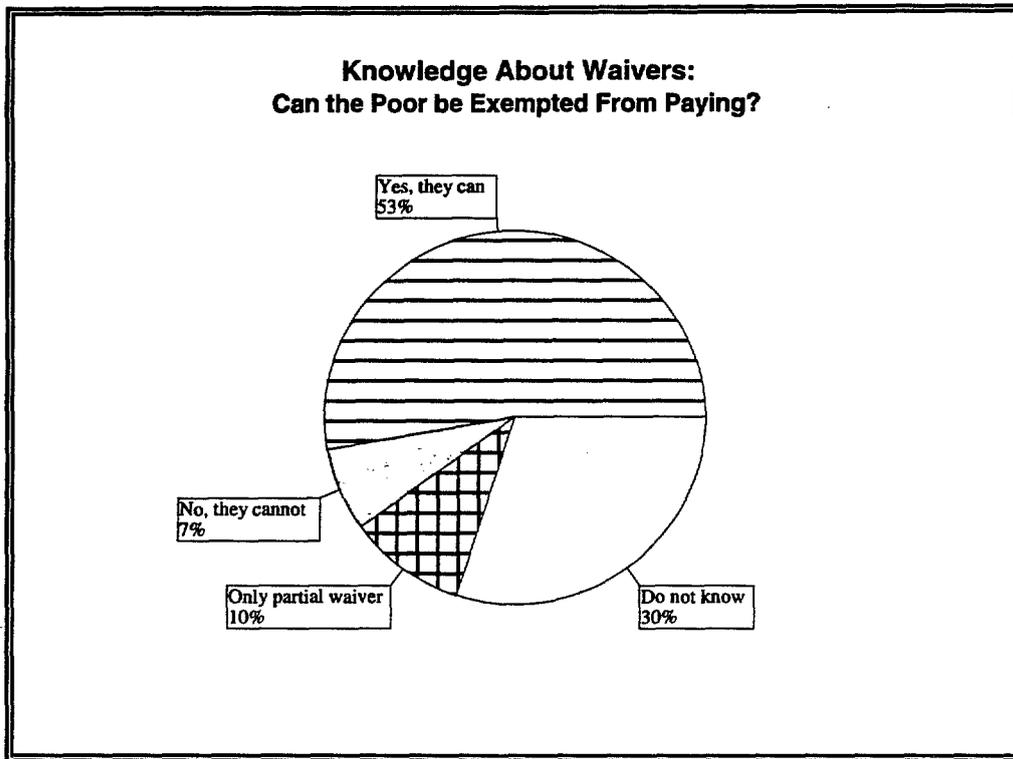
Figure 7



6.8 Knowledge about waivers and the source of the knowledge

To determine whether the public was familiar with the existence of and policy on waivers, interviewees were asked if the poor could obtain waivers of health facility fees. Thirty-seven percent erroneously believed they could not obtain a waiver or did not know. This was consistent with the findings of the survey of health facilities, which revealed there was no formal mechanisms in place for communicating with communities and the poor about the existence of waivers for the poor.

Figure 8



To learn the source of this information, interviewees who knew of waivers were also asked, "How did you learn that the poor do not have to pay?" Table 5 reflects that health staff and acquaintances are the primary means to learn of waivers.

Table 5: Source of Information about Waivers

| | TOTAL | Poor | Non-poor |
|---------------------------------|-------|------|----------|
| Health staff | 40% | 33% | 61% |
| Friends or relatives or both | 44% | 44% | 39% |
| Signs posted at health facility | 0% | 0% | 0% |
| Other | 16% | 13% | 0% |

6.9 Knowledge about exemptions

Similarly, to assess knowledge about exemptions, interviewees were asked if certain categories of patients or people with specific diseases were exempted from paying for health services. The percentages in Table 6 represent the proportion of interviewees responding affirmatively that the patient category named was exempted. MCH and family planning services are the best known exemption categories.

The list given to the interviewees included categories of patients that were formerly exempted but are no longer exempted, including civil servants, health workers, and all children under 18. The survey revealed that 38 percent of the respondents thought health workers were still exempted. Only seven percent thought the other erroneous patient categories were still exempted.

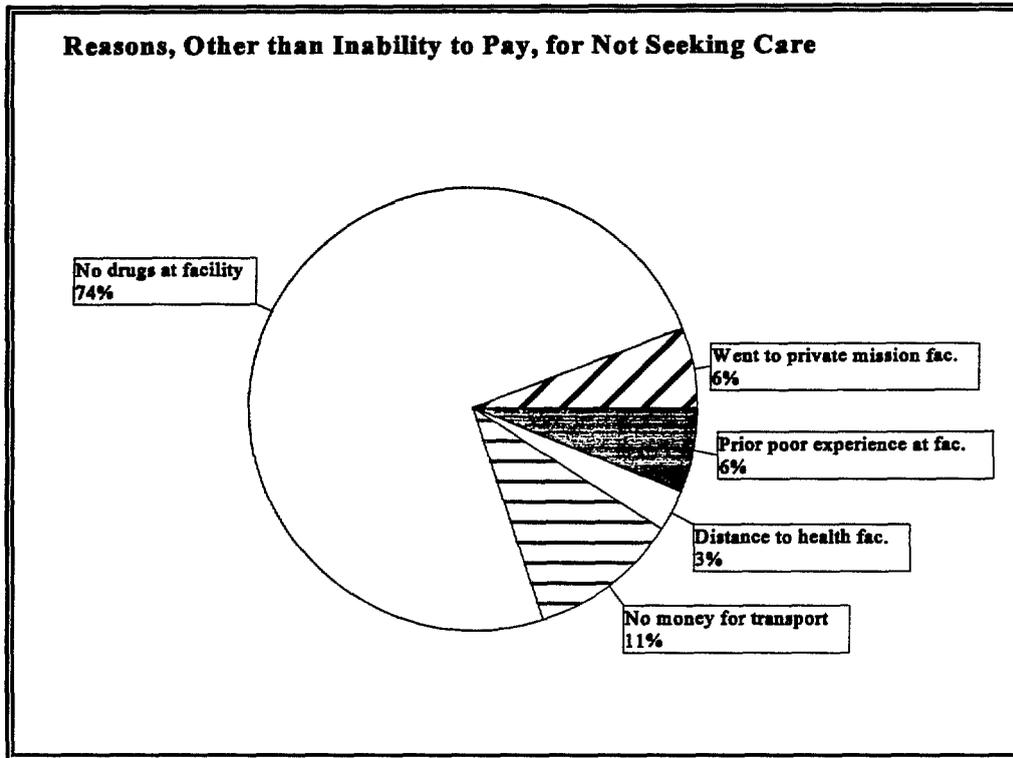
Table 6: Interviewees Knowing the Following Categories are Exempted from Fees

| Exemption Category | Percentage positive responses |
|-------------------------------------|--------------------------------------|
| Children 5 years of age and younger | 63% |
| Child health clinic | 48% |
| Family planning | 39% |
| Antenatal clinics | 46% |
| TB patients | 15% |
| Leprosy patients | 2% |
| AIDS patients | 15% |
| STD patients | 15% |

6.10 Interviewees' knowledge of others not receiving care

To attempt to learn the extent of any additional undercoverage, interviewees were asked if they knew anyone who had not come for care due to inability to pay or for other reasons. Ninety-one percent stated they knew someone who did not seek care because he/she could not pay for it. Ninety-four percent stated they knew someone who did not seek care for some reason other than inability to pay. Figure 9 shows the reasons given by the interviewees for their acquaintances not seeking care. Besides than lack of money, the lack of drugs at health facilities was the overwhelming reason patients did not seek care. This does not bode well for the patients of the MOH facilities continuing to experience persistent shortages of drugs.

Figure 9



7. Experiences with Waivers: Findings from Government Health Facilities

The information presented in this section is based on interviews with administrators and clinical staff at government health facilities and review of the institution's records. The results from patient exit interviews at these facilities are presented in another section.

7.1 Functioning of the systems and application of guidelines

Staff had some familiarity with the waiver process and procedures at all but one government institution: While all government health facilities had a uniform policy on the waiver and exemption system, it was implemented and applied differently at the various facilities. Staff had some familiarity with the waiver process and the procedures for their approval at most government institutions. However, there were instances of staff possessing misinformation about the system as well. For example, at Kendu Bay Health Center, the officer in charge (OIC) was unaware of the proper procedure for application and approval of waivers; instead, he continued to use old standards for approval of waivers. He had the proper forms, but did not realize he had the authority to approve the waivers. He stated patients were required to obtain the waiver form from their village chief and then secure the OIC's approval in order to have fees waived at the health center. Parenthetically, he noted that for some reason he had never received an application for a waiver during his tenure. This was the old procedure from several years previous.

In other instances, the procedures for completing the necessary forms were known but were not followed. At Homa Bay District Hospital, the pharmacist did not believe the system worked, so he approved total and partial waivers at the pharmacy as patients presented who claimed not to have sufficient cash to have their prescription completely filled. His circumventing the system was done in the interest of the patients. He felt he could interview the patients on the spot and make a quick determination if they could make a payment or not, even if it was a partial payment. He felt it was more important that the patient receive the complete prescription and pay what he/she could pay than to withhold the drugs or only fill the prescription partially until complete payment was made.

Authority for granting waivers was uniformly vested in the medical superintendent or officer in charge for inpatient care at hospitals and health centers. This was consistent in all facilities except at New Nyanza Provincial General Hospital, where the medical superintendent had designated an assistant administrator who would review and approve all waiver applications. This designated person was solely responsible for all aspects of the waiver program: reviewing all cases, approving or disapproving, and advising staff of the procedures.

Exemptions were applied uniformly across the various facilities: Exemptions could be granted immediately because a patient had a certain characteristic, such as being a child under five years of age. This identification of a patient as having or not having a characteristic makes the exemption system a simpler process than that for waivers. The staff were involved in the process of granting exemptions,

since this happened at the point of service. In addition, exemptions are simpler because they do not require any approval beyond the staff member providing the service. As indicated in the section on patient exit interviews below, it was often the staff who made patients aware they were eligible for waivers and exemptions.

Guidelines for determining eligibility for waivers were determined locally at each institution, but seldom formalized: The guidelines for determining eligibility for waivers varied among facilities. In the largest hospital with the most patients — Kenyatta National Hospital (KNH) — the guidelines were the most formal. There the hospital social workers used interviews, review of patient records, observation of patients and their families, and direct interviews with patients and their families for gathering information to determine whether to recommend that the patient receive a complete or partial waiver. This was a unique situation not observed at the government institutions, which may be related to the fact that KNH, as a state corporation, is different from other government hospitals because it has more liberty in decisions taken and has more staff. At other facilities there were virtually no waivers granted so, de facto, there were procedures but no formal guidelines for granting waivers.

The administration of the government health facilities emphasized generating revenues rather than ensuring access to the poor: Consequently, the government facilities minimized non-leakage of the system at the expense of increasing the undercoverage rate. The pressure that facilities felt for generating revenues resulted in making waivers extremely difficult to obtain at government facilities: three of the five government institutions gave no or nearly no waivers. The administration at these facilities were more concerned about leakage in the system (i.e., the non-poor requesting and receiving waivers) than about undercoverage (i.e., the poor not receiving waivers they were entitled to). The result was a stringency in granting any waivers to ensure that the non-poor did not obtain unwarranted waivers. Little consideration was given to the fact that there may be some poor patients who should receive waivers for care and do not, or that some are deterred from even coming to the facility because they are not aware they would be eligible for a waiver of the fees.

This emphasis on generating revenues extended beyond the health facility administration and staff. At Pap Onditi Health Center, discussions were held with the village chief and village health committee by the writer of this report. The chief and committee stated they were most concerned about generating revenues so new equipment could be obtained and their local health facility could then be upgraded to a sub-district hospital. They were not concerned about there being poor who could not pay and thus not receive care since they felt they would know about it if that were the case. Subsequent household interviews in that area revealed there were poor people who did not seek treatment for lack of money and because they believed no waivers would be granted.

Staff dealing directly with patients felt they were not truly involved in the process of granting waivers: The nurses on the wards and in the clinics were a continual source of information for the private health facilities, but were used in only one of the government facilities. At one government hospital, the nurses stated that since their recommendations were seldom followed, they no longer attempted to recommend that certain patients receive waivers. The administration made the ultimate decision and seldom consulted the unit where the patient was being treated. The staff said that since the administration's

concern was generation of revenue, a waiver was never granted; thus there was no purpose in advising patients about the process for obtaining a waiver. These staff expressed concern that the system for granting of waivers was too inflexible.

Patients were held for long periods after completion of treatment until they could pay their bill: When inpatients were ready for discharge but could not pay their bill in full, they were returned to the ward until family members could obtain the money. During this time, the patients continued to accrue additional charges, thus the bill grew larger, making it even more difficult for patients to pay their bill and even harder to be discharged. In addition, inpatients who had been in hospital 14 days had their fees capped by the exemption system and thus the hospital incurred additional costs for all inpatient days beyond 14 days that could not be recouped from fees. An additional problem of this policy was that it reduced the available hospital beds for new admissions. Only one facility, New Nyanza Provincial General Hospital, recognized that such procedures were not "cost-effective": the costs of keeping patients in hospital to incur additional costs that would not be recouped and preventing additional admissions that may generate revenues exceeded the marginal revenues that would be generated by keeping patients longer.

At this provincial hospital, inpatients had to pay in advance before x-rays or laboratory tests were administered. Thus, surgery and other services were delayed several days until the patient obtained the money for the diagnostic tests to be performed. This again resulted in patients occupying hospital beds, which prevented admissions and incurred additional costs for the hospital beyond what would be recouped in fees (due to the heavy subsidization of actual costs) because patients were occupying beds but were not being treated.

For the outpatient services, no drugs were issued or laboratory tests or x-rays taken until the charge for the service was paid. The pharmacy would often partially fill prescriptions that could not be paid in full. The pharmacy did not contact the physician prescriber to determine if partial filling of the prescription was medically acceptable. Some patients returned with payment to receive the remainder of their prescription. Often, however, the patient who only received a portion of the total prescription did not return. Thus, patients either did not have all the drugs they should have or did not have a full course of the single drug they needed, or both.

Records and monitoring of the waiver and exemption systems were nearly nonexistent: Though the MOH procedures existed for facilities to report monthly their revenues collections from fees and the value of exemptions and waivers granted, such reports were not maintained or available at most facilities: only one facility kept records on the actual number of waivers granted. At the facilities where records were kept, there was no monitoring of the number and value of waivers granted. The emphasis was only on reporting the revenues generated each month.

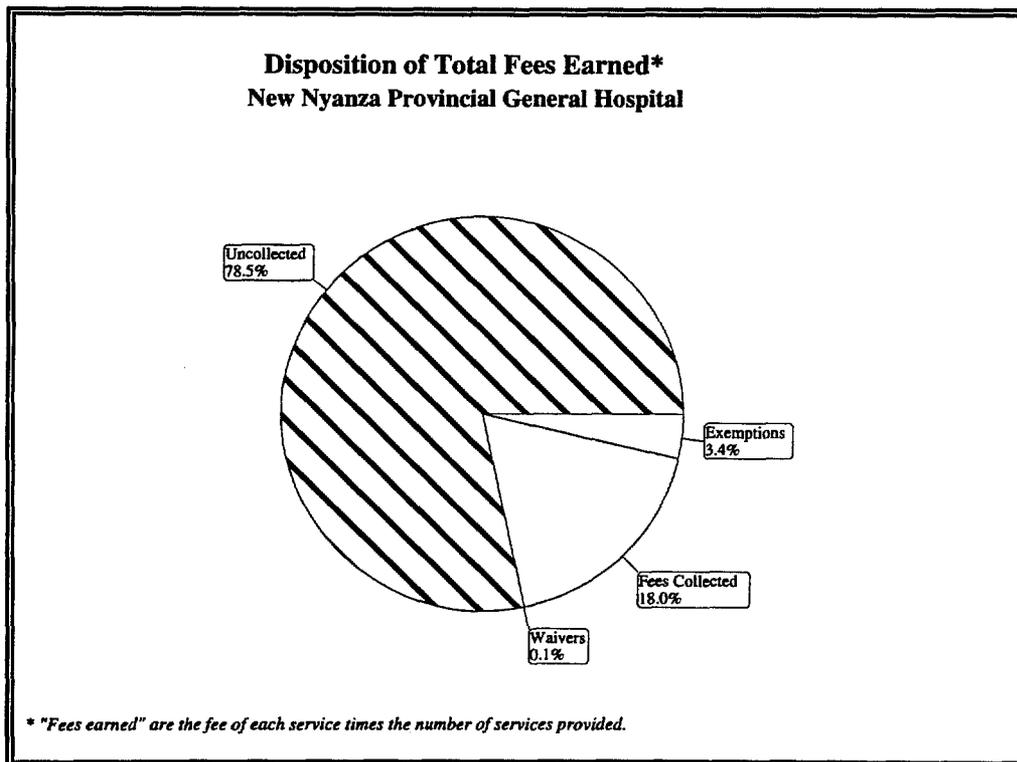
7.2 Number of waivers granted and cost of the system

The waivers granted and their value are minimal: There were few waivers given, as shown in Figure 10. At the two government institutions granting waivers — the hospitals in urban areas — the value was less

than 0.5 percent of the annual budget at the large hospital and 0.01 percent at the other. As indicated above, due to lack of records, the number of waivers granted and the value could not be determined at all government health facilities. At one provincial hospital, the average number of waivers granted was 10 per month, which was a very small percentage of all patients seen at the facility. If fees had been charged for all services provided, the actual revenue collected was 18 percent of the total fee that could have been charged. Exemptions accounted for 3.4 percent of the total and waivers for less than 1 percent. The small percentage of waivers granted is consistent with the 1993 study by Quick et al., which found that less than one percent of prescription items were dispensed against a waiver and less than one percent of laboratory fees were waived. These fees reflect only a portion of actual costs incurred for each service. At the large referral hospital, there were many more waivers, representing 13 percent of fee collections, while exemptions were 15 percent of fee collections. In absolute terms, waivers were valued at KSh. 4 million out of a budget that approached KSh. 900 million. As indicated below, the value and number of waivers were much higher at the private institutions.

Generally it was observed that rural government institutions granted few or no waivers; in contrast, the urban institutions made use of waivers. Yet the waivers granted were minimal in comparison to the total services provided.

Figure 10



The actual costs of administering the system are low. There is no information campaign, no training of staff in the system, and there are no multiple forms or processes. The primary direct cost of this system is the staff time required to obtain information from patients and complete waiver forms. In those facilities that have individuals dedicated to overseeing revenue collections and waivers, the proportion of those staff members' time spent on administering the waiver system would be a direct cost. At the national referral hospital, there are a number of social workers involved in this process of granting waivers, so their costs would be higher than other facilities. Overall, however, the direct costs of administering this waiver system are minimal.

Hospitals granted waivers "involuntarily" when inpatients absconded: Though formal waivers were few, there was an informal means of patients obtaining a waiver: absconding. Absconding occurs when patients depart the hospital on their own without properly being discharged, and thus without paying their hospital bill. This was a problem at most institutions, though the number and value of the services given to absconding patients was unknown. It was estimated to be as high as 20 percent of inpatients. The number of absconding patients who were poor is unknown.

The national referral hospital had a higher proportion of patients eligible for waivers due to referrals: The higher number of waivers in the national hospital were due, in part, to the hospital being a referral hospital. Other government hospitals referred many patients to this hospital, and many of these referred patients could not pay for their services in full. This resulted in two problems for the hospital: first, it had a much greater proportion of patients who were eligible for waivers, and second, in addition to receiving little or no payment for the services provided due to patients unable to pay, the hospital incurred additional costs for those patients. When many of them had to be referred back to the provincial or district hospital, the national hospital often had to provide transport money for the patient. This situation added to the costs of the waiver system for the national hospital.

In addition, the private hospitals in urban areas transferred all non-emergency patients who were unable to pay to the government hospital. To minimize the free care given to patients not requiring care at a tertiary care hospital, those patients who were emergency cases and could not pay for services, were treated and then transferred after their condition stabilized.

7.3 Use and non-use of the waiver system by the poor

Undercoverage was a problem: The waiver system did not provide the poor with any increased access to health services. The low number of waivers and the small proportion they represent of the total revenues of the government facilities indicate that the waiver system has not necessarily increased access. This was substantiated in the household interviews, which revealed that many poor did not seek care because of their inability to pay and their belief payment was required for receiving treatment at public and private facilities. The health facility staff corroborated this finding in reporting that not many people were turned away from treatment for non-payment because people in the surrounding area knew about the fees and payment was required of everyone. Thus, the patients did not show up at the health facility in the first place unless they had the money to pay. As a result, few patients had to be turned away for

lack of money because those presenting for care were a self-selected group that knew they could pay the fees.

Leakage was not a problem of the waiver system: The tight controls in granting waivers ensured there was minimal leakage (i.e., the non-poor receiving waivers). If few waivers were granted, it follows that very few non-poor received waivers (just as very few of the poor received waivers).

7.4 Public information about the waiver and exemption system

There was no active communication by health facilities to the communities or individual patients on the existence of the waiver system and the process for obtaining waivers and exemptions: The emphasis on revenue generation by government facilities resulted in the facilities not providing any information about waivers or exemptions to communities or patients. At each facility, administration and staff stated that fears about abuse of the waiver system meant they sought not to publicize it. No informational signs about waivers were observed in any of the institutions. They acknowledged that some poor who should be granted waivers might not be able to access health care without that knowledge. However, the concern about leakage overrode the possibility that some poor would lack access to care.

This finding was validated by the patient exit interviews and household interviews, which indicated patients had almost no knowledge about waivers (no fees paid due to patient being poor); however, they did have some knowledge about exemptions (exempted from fees due to patient having a certain characteristic). Most information the community members and patients had came from friends or relatives.

Explanation by staff and word-of-mouth among friends and relatives were the most common means of communicating information about waivers and exemptions to patients: As there was no formal communication channels or campaigns about waivers and exemptions to communities, most of the information patients and communities had was obtained informally through either a concerned health staff member who knew of a patient's plight or from family, friends, or other patients. The patient exit interviews substantiated this finding that these were the two primary sources of information about exemptions. However, there was very little information about waivers from any source. This was due, in part, because not many waivers were granted, so there were few patients or relatives who had first hand knowledge about waivers that they could communicate to others.

7.5 Staff training and knowledge of the system

No formal staff training existed to explain the policy and procedures for waivers and exemptions: Only one government facility had provided a briefing to staff members on waivers and exemptions. The administration of health facilities stated that staff would learn about waivers and their role on an "as needed" basis through supervisors, other staff, or staff circulars. Health staff stated that the only sources of knowledge they had about the waiver system was obtained informally from other staff. They contradicted the administration in saying no information was obtained from staff meetings, circulars, or

training sessions. The result was some information and training on waivers was provided to managers, but not to the health staff who administered the system in their dealings with patients.

7.6 Efficiency and effectiveness of the system

The system had low leakage but high undercoverage: The facilities are effective in minimizing leakage so the non-poor who come for care do not receive waivers. The costs of this minimal leakage, however, was an increase in undercoverage. The data from household interviews supported this view that few of the poor received waivers. As there had been no baseline survey, it is not known if this situation reflects a situation in which undercoverage has not changed or if it has worsened for the poor.

Strictness in applying guidelines for waivers resulted in ineffectiveness in identifying and granting waivers to the poor who come for care: The government facilities are not effective in minimizing undercoverage because the current system is not effective in reaching those poor who require care but do not present for treatment at the facility. The interviews at health facilities substantiated this finding. Much of the health facilities' actions are based on the administration's view that because there is not much outcry among patients about the lack of waivers, and the patients continue to come and pay, there must be no undercoverage problem. However, this view is based on the information obtained only from those patients actually coming to the facility for care. The findings of the household and patient exit interviews indicate there are many people who do not seek care because they cannot pay. Often these poor only seek care once their condition is extreme.

Keeping inpatients until they pay their bill is not a cost-effective decision: As noted above, it is a common practice not to discharge patients until their bill is paid in full. These patients are returned to ward and continue to accrue additional charges while family members seek funds to pay the hospital bill. At the same time, they congest the wards and occupy a bed, which cannot be used for other patients. Sometimes the hospital ultimately discharges the patients with only a partial payment as it becomes obvious the money to pay the bill in full will not be forthcoming. However, during the interim while the patient's family seeks money to pay, the hospital accrues additional expenses for this patient's care. Often the charges for these additional services are never recouped. Only one facility recognized the consideration of "cost-effectiveness" in making decisions about how long to keep patients after treatment is completed in an attempt to obtain full payment. Such considerations were ad hoc, however, and not formalized as part of the hospital's decision-making process in granting waivers.

Decentralizing decisions for waivers for small threshold amounts could minimize the costs of granting waivers: At the national referral hospital where the most waivers are granted, the process requires that social workers gather information, make a recommendation on the waiver eligibility, and then obtain the signature of one of two administrators. Due to the time involved to complete this process, the hospital has determined it is more cost-effective to give authority to the social worker to make decisions about waivers for amounts below KSh. 2,500. This speeds the decision process, which means administrators only have to review the high cost waivers, and it minimizes congestion of the wards with non-paying patients who should be discharged. It was decided the value of these waivers was low enough that to use the usual process would greatly increase the cost of granting waivers.

7.7 Summary and Conclusions: What worked in government health facilities

The exemption portion of the system worked well: The above comments may appear to reflect a view that the existing systems for waivers and exemptions are not working well. In fact, there are positive points. The exemption system does work well. This is because patients with the given characteristics are easily identified at the point of services, granted the exemption, and the services rendered. The staff readily inform patients, such as those at child health clinics, that there is no charge for the services. Thus the following comments are a discussion of the waiver system intended for the poor.

The waiver system does not currently protect the poor: There are positive characteristics of the waiver system. The system for determining waivers is simple and decentralized in that it is not run by the central ministry. The waiver process has two steps for inpatients; the process for outpatients has only one. Each local institution determines the criteria it will apply in granting waivers. In addition, it is the local institution's chief executive who has the authority to grant all waivers at that facility. The cost of administering the system remains low because the system is not too bureaucratic or administratively burdensome. It is useful to have a decentralized waiver system for determining guidelines and using the staff in applying them. These are key components that are positive and can be emulated by others.

Unfortunately, the simple system does not protect the poor because few waivers are granted. This is due to a combination of factors: the emphasis on revenue generation, lack of knowledge and training in the waiver system for health facility staff, and lack of communication with the community about waivers.

What worked best was having a health staff member dedicated to dealing with waivers: In both public and private institutions where one individual deals with the waivers, there is much greater consistency in the application of the criteria. In addition, the individual gains a greater ability to ascertain those cases that are truly needy. At Kenyatta National Hospital (KNH), this role was played by social workers. The social worker served as an intermediary between patient and administration. This facilitated the granting of more waivers to those who needed them. It also provided a check and balance system to minimize potential internal abuse; waivers were granted on a uniform basis, rather than only to friends or relatives of staff members.

8. Experiences with Waivers: Findings from Non-government Health Facilities

8.1 Functioning of the systems and application of guidelines

Facilities did not have a formal waiver policy for the poor, but each made informal provisions for the poor: The private facilities did not have any formally established waiver systems. For the rural private facilities it was recognized that some patients might not ultimately be able to pay their bills in total, but every effort was made to seek full payment of charges. When the medical superintendent felt the facility had obtained the largest possible payment the patient could make, they would discharge the patient and invoice the patient for the balance. Usually about 35 percent of these outstanding balances were eventually paid in full by the patients. The remaining accounts receivable were eventually written off as uncollectible bad debts. It is these "bad debts" that are the de facto waivers granted by the private health facilities.

There are no exemptions at private health facilities: Most of the private facilities had no services or categories of patients for which there were exemptions. Certain services that were "public goods" or had externalities were provided free or at minimal charge at some facilities such as child welfare clinics. Other key services were often provided below actual cost, so in effect the fee charged was subsidized. For instance, at some of the facilities, a number of the services such as child health clinics and antenatal clinics charged lower than usual outpatient and consultation fees to encourage use of the services. However, the private urban facilities made no such provision for subsidized fees and charged full costs regardless of the service since there was sufficient demand for those services despite the high fees.

Rural mission hospitals were successful in balancing the serving of people with the need to pay the bills: The private health institutions established workable systems for meeting their financial needs while recognizing that some poor patients cannot pay their bills. The rural private facilities had a unique focus: balancing the need for financial soundness by obtaining payment for services rendered versus the recognition of their mission to serve people and communities by providing services based on need and not ability to pay. The result was that no one was denied care due to inability to pay. This did not mean, however, that the mission facilities were cavalier in granting waivers. The private facilities recognized that the ultimate reason for their establishment had been to serve the health needs of their surrounding community and were dedicated to this end. They also recognized that they must be able to meet their expenses through patient revenues and donations or else the facility would cease to exist and would no longer serve the community. As a result, the rural facilities worked with local community and church leaders to explain the business aspect of running a hospital and the necessity of patients paying for the services received. The community leaders, recognizing the hospitals as a community resource, assisted in communicating this, as well as helping the hospitals to obtain payment from as many patients as possible.

Private mission facilities more readily accepted partial payments: Unlike the government hospitals, the private hospitals recognized that keeping patients too long while they waited for them to obtain money to

pay their bills became very expensive as charges continued to accrue. In addition, holding patients who could be discharged prevented the hospital from serving other patients. Not having free beds meant they could not generate additional revenues if beds were being occupied by those no longer being treated. So private facilities accepted partial payments and invoiced the patient for the remaining balance rather than keeping the patient at the hospital until the bill was paid in full.

Charity funds were established by some mission hospital so they had money to grant waivers: Two mission or church hospitals had established charity funds, termed *Needy People's Fund* and *Poor Patients' Fund*. Churches, communities, suppliers, and donations from other churches outside the country were used to obtain monies each year for these funds. These funds were then used to cover charges for particular patients who could not pay all or part of their bill. The payment was not granted immediately but at the end of the fiscal year, usually. The existence of the funds was not made known to patients. The funds were used to pay off balances of those accounts when it appeared the patient would or could not make any further payments. Outstanding balances were often carried on the books of the hospitals for several years while some attempt was made to collect what was owed. A drawback of these charity funds was that a great deal of effort was required to generate money for these funds. One of the hospitals with this type of fund was seeking to generate a larger amount and set it up as an endowment so the amount of money that must be raised each year was not so great over the long term.

Private facilities have a more centralized process with greater staff participation for granting waivers: At the private facilities, the waiver process was similar to government hospitals in that the medical superintendent or administrator had to approve all waivers. Granting a waiver was, in essence, accepting a partial payment from the patient, discharging the patient, and invoicing him or her for the unpaid balance due. Compared to government hospitals, accounting and administration played a larger role and nursing and ward staff played a lesser role in granting these waivers, compared to government facilities. Unlike government facilities, the health staff at mission hospitals felt they still had a key role in the process because they were asked by administration about the patient and family when a waiver was being considered. One facility recently employed a social worker to assist them in granting waivers. The social worker served as a liaison between the patient (and his or her family and community) and the hospital's nursing and administrative staff. The social worker was able to have a better understanding of the patient's ability to pay after talking with community leaders, as well as suggesting creative ways for the bill to be paid without unnecessarily holding the patient longer in hospital.

Mission facilities had "early warning systems" to alert them of patients with potential problems in paying their bill: The private facilities had a number of mechanisms that alerted them soon after admission of any patients who might not be able to pay their bills in full. These mechanisms included: (1) requiring deposits before admission or outpatient treatment; (2) regularly requiring additional deposits that reflected the additional charges being incurred to be made by patients or relatives as their hospital stay continued; and (3) invoicing patients frequently during their hospital stay so they knew the amount of their accumulated bill. The invoicing of patients and their family one or two times each week ensured they knew the extent of the accrued cost of the services they were receiving so the final bill would not be a "shock."

Good recordkeeping and monitoring systems of waivers by private facilities: The private facilities had good systems for recording and keeping track of the number of waivers and the amount of full or partial waivers. These were systems closely tied to their accounting systems. Thus, most private facilities readily knew the number of patients granted full or partial waivers and the value of the waivers granted, as well as the outstanding balance of unpaid hospital charges accrued by patients.

Private facilities shifted some of the poor to government facilities: Some of the urban private facilities sought to minimize their bad debts or the involuntary granting of waivers (due to inability to pay or non-payment by patients) by quickly transferring patients who could not pay to government facilities. They all treated emergencies without question, but if there was an apparent inability to pay, the patient was transferred to the government referral hospital as soon as the patient's medical condition was stabilized.

8.2 Number of waivers granted and cost of the system

Rural institutions made wider use of waivers: Rural facilities were smaller than the large government referral hospitals, and the waivers ultimately granted as accounts receivable or bad debts were substantial. The Kendu Bay Adventist Hospital granted an average of KSh. 1 million in waivers each year while operating on a budget of KSh. 30 million. The number of full or partial waivers granted by the hospital averaged between 30 and 50 a month over the last three years. The average value of each waiver granted was KSh. 5,042 per patient. Though patients were discharged even if the bill was not paid in full, they were invoiced for the balance. Patients were never granted a total absolution of all charges upon discharge. The results of this invoicing method were encouraging: nearly 38 percent of these patients who were invoiced upon discharge repaid the "waiver" in full within six months. On any given month, the monies generated by repayment of these waivers represented between 23 and 50 percent of the value of the new waivers granted by the hospital that month. Further, by invoicing the amount unpaid, over time the hospital recouped nearly 40 percent of the total value of all waivers granted. By contrast, the large government hospital, KNH, had a total budget which was 30 times that of the mission hospital (KSh. 900 million), but the value of the waivers granted (KSh. 4 million) was only four times the value of waivers granted at this church hospital.

At another mission hospital, in a rural and poorer area, 55 percent of patients paid their bills in full, 5 percent made partial payments, and 40 percent were unable to make any payment at all. The value of waivers granted (that is, patients invoiced with little expectation of repayment) accounted for 40 percent of the hospital's budget. The average value of waivers granted was KSh. 14,000, with total annual waivers of KSh. 800,000 to 1,000,000. The hospital indicated it currently had waivers (or accounts receivable) from past years of KSh. 24 million. The number of waivers per month was in excess of 350, many of which were for outpatient charges.

Another facility had bad debts from waivers granted over the years of nearly KSh. 6 million. This institution granted 30 to 50 waivers per month, with an average invoice amount (the amount unpaid upon discharge) of KSh. 7,500. In an effort to reduce this amount while ensuring that those truly in need were not denied access to services, the hospital was seeking to collect as many of the accounts receivable from the past four to five years as possible and then write off the remainder as bad debts. In four months they

had collected nearly 10 percent of the outstanding balance. They were also attempting to minimize future bad debts by having consistent criteria in granting waivers and using a social worker to relieve the administrator of this duty, as described below. For the month of October 1994, 52 patients were discharged without having paid their total bill. The outstanding balance of unpaid bills was KSh. 391,790 from these patients. As of April 1995, 28 of these accounts with a total balance of KSh. 130,369 were still outstanding. This reflects a repayment rate by 46 percent of the patients receiving waivers, representing a recovery of 67 percent of the value of the waivers granted.

This hospital also had an innovative means for dealing with the issue of hospital staff wanting special treatment for friends or relatives who were inpatients and reducing or waiving their fees. The hospital does not allow this, but will allow hospital staff to guarantee the payment of a friend or relative. If the outstanding amount is not paid within six months, it is deducted from the staff member's salary. One other problem was that some ward staff would remove portions of a relative's inpatient medical record so that the accounts department could not bill for all services rendered. The hospital administration has reduced this by explaining to staff the need to obtain fees to meet the institution's budget. Removal of records and thus reduction of the fees collected by the hospital will ultimately affect the staff, because if the hospital could not meet its budget, it would necessitate that staff not receive pay raises or possibly result in reductions in pay. The result of making staff aware of the personal consequences of their defrauding the hospital of fees has been a substantial reduction in staff attempts to reduce charges for their relatives and friends by destroying medical records.

Taking corrective action for the future, this hospital has employed a social worker. The social worker liaises with patients and their families and the hospital accounts department for payment of bills. If there appears to be a problem, she makes an unannounced visit to the patient's home and village chief to ascertain if this is truly a case of the patient being indigent. During these visits to communities, the social worker also comes across some very sick individuals who have not sought treatment. The social worker has the authority to grant these sick individuals an immediate waiver so they can go to the hospital for immediate treatment. Based upon her recommendation, the hospital administrative committee would approve or deny the waiver. For a period of time the outstanding balance was carried as an account receivable. Later, the administrator might pay the account in full from the Poor Patients' Fund if it appeared the bill would never be paid by the patient.

At some of the urban private facilities, as much as seven percent of the budget is accounted for by patients who do not or cannot pay their bills. These are usually for emergency patients, as non-emergency patients who cannot pay are not treated or are quickly transferred to government facilities.

Private urban institutions did not grant waivers except for emergencies: The urban private facilities had no "Poor Patients' Funds." Only emergencies were treated if the patients could not pay. The hospital then transferred the patients to government facilities. The value of these involuntary waivers granted was high at urban facilities, though the number of actual waivers granted involuntarily was very low. This reflects the substantially higher user charges at these facilities.

8.3 Use and non-use of the waiver system by the poor

Undercoverage continues to exist: Waivers granted by the private facilities are primarily for the truly poor. Some of the truly poor may not receive waivers, as the facilities attempt to have the extended family and the communities assist in providing the necessary funds for treatment. The patient exit interviews substantiated this strictness with waivers, with the poor stating that a major source of money for health services is from friends and relatives.

The private facilities seek to minimize the number of waivers they grant through bad debts. As a consequence, it is only those who truly cannot pay who receive waivers. This results in the potential risk that there is undercoverage, as evidenced by the social worker who finds people in the community who require care and do not seek it due to concern about the fees. At that particular hospital, the social worker visits the home and village chief to ascertain eligibility for partial or total waiver. She helps to reduce undercoverage by referring to the hospital the very sick patients she has found in the village, and granting immediate waiver if payment was the access barrier preventing their seeking care. However, this is not a systematic effort to seek out those who require care but cannot pay, so there continues to be undercoverage in these areas, though it is less than that in areas serviced by government health facilities.

In the urban areas, the private hospitals transfer of non-paying patients to the government hospitals means that the urban poor only have the option of seeking care at government facilities if they cannot pay. Since the private facilities charges may be 10 to 20 times the public facility charges, they can only seek care at private facilities if they can raise sufficient money from friends and relatives. The result is a higher number of waivers at the national referral hospital.

Leakage is minimal: Similarly, since the private hospitals are cautious in granting de facto waivers, the opportunity for the non-poor to receive waivers is minimal. Because the private facilities investigate each potential case of granting a waiver, there is minimal opportunity for the non-poor to receive care at no charge.

8.4 Public information about the waiver and exemption system

The existence of waivers for the poor is not publicized to the community: The existence of the Poor Patients' Fund or the possibility of patients being discharged without paying their bills is not presented by the private hospitals to the community or patients. Concerns about loss of revenues and leakage in the system are the primary reasons for this. Though there is no formal information provided about waivers, there are informal channels of communication, as described below.

Friends and relatives are the most common source of information on waivers: As in the public facilities, the informal, word-of-mouth spread of information among friends and relatives was the most common way for patients to learn of waivers.

8.5 Staff training and knowledge of the system

Generally, there is no formal staff training about waivers: The private hospitals did not have any means of training or explaining to their staff the policy on waivers. Part of this was because the accounting or revenue office and administration were the primary areas to deal with this issue. There was one exception of a mission hospital that did have formal training for staff in how to deal with patients and their ability to pay.

8.6 Efficiency and effectiveness of the system

There is minimal effectiveness in reaching those poor in the community who do not come to the health facility: With the exception of the one private hospital mentioned above, there is no systematic attempt to ensure that the poor in the community have access to services. In the rural areas, the private mission facilities do try to ensure access to some extent, because their mission statements explicitly state that they are to provide care regardless of ability to pay. The lack of formal mechanisms to ensure access, however, results in undercoverage.

Facilities are effective in identifying those patients at the facility who are truly poor and granting them waivers: The private facilities appear to invest more time and effort to ascertain the validity of a patient's claim of inability to pay. The rigors of reviewing each case may result in undercoverage, however, especially in those hospitals where the accounting department (rather than a social worker) is responsible for determining eligibility. Overall, though, they do help many of those poor who come for care, as illustrated above by the amounts some of the hospitals provide in free care to those patients who cannot pay their bills.

Facilities are effective in minimizing leakage: The private hospitals are effective in ensuring that non-poor who come for care do not receive waivers, primarily because the private hospitals in rural areas know their community and work with their community leaders to identify the poor.

8.7 Summary and Conclusions: What worked in private health facilities

- Rural hospitals have simple procedures.
- Having a dedicated staff member to assist patients in need has improved the waiver process.
- Working with the community to identify who cannot pay has improved consistency in the granting of waivers.

The rural private hospitals continued to work with their communities to identify those who could pay and those who could not pay. One facility's use of a social worker as intermediary facilitated more waivers being granted to those in need. This sort of system also provided checks and balances so waivers were granted on a uniform basis, rather than only to friends or relatives of the staff. Having a dedicated individual (such as a social worker) to deal with waivers facilitated consistency of application of guidelines. This individual visited the patient's home and the village chief before granting a waiver.

9. Summary and Conclusions

The above findings indicate there are positive and negative aspects of the waiver and exemption system and its operation in Kenya.

Positive:

- some poor are receiving free care under various exemption categories (characteristic targeting); and
- the low levels of fees — especially for inpatient services — and the safeguards in the fee structure, mean that no patient is exposed to a catastrophic financial risk. The maximum bill a patient is likely to pay is not more than about KSh. 800 at a provincial government hospital and about KSh. 600 at a district hospital.

Negative:

- some poor people are not getting treated at government facilities because they don't know waivers are available; and
- some poor people are paying for treatment at government facilities when they should not be, because they do not know about waivers and staff do not want to publicize them.

Below are some specific points which summarize the findings of the study, followed by the recommendations in the final section.

9.1 What worked in government health facilities

The above comments may appear to reflect a view that the existing systems for waivers and exemptions are not working well. In fact, there are many positive things about the system. The exemption system appears to work quite well. This is because patients with the given characteristics are easily identified and the services provided. The staff readily inform patients, such as those at child health clinics, that there is no charge for the services. Thus the following comments are a discussion of the waiver system intended for the poor.

Positive characteristics of the system: The system for determining waivers is simple and decentralized in that it is not run by the central ministry. Each local institution determines the criteria it will apply in granting a waiver. In addition, it is the local institution's chief executive who has the authority to grant all waivers at that facility. Thus the system is not too bureaucratic nor administratively burdensome. The cost of administering the system remains low. The waiver process has two steps for inpatients; that for outpatients has only one. It is useful to have a decentralized waiver system for determining guidelines and using the staff in applying them. These are key components that are positive and can be emulated by others.

Having a dedicated individual to deal with waivers facilitated consistency of application of guidelines: In both public and private institutions where one individual deals with the waivers, there is much greater consistency in the application of the criteria. In addition, the individual gains a greater ability to ascertain those cases that are truly needy. At the tertiary facility, Kenyatta National Hospital (KNH), this role was played by social workers. The social worker served as an intermediary between patient and administration. This facilitated the granting of more waivers to those who needed them. It also provided a check and balance system to minimize internal abuse — waivers were granted on a uniform basis rather than only to friends or relatives of staff members.

9.2 Formalizing Some Guiding Principles

Guiding principles for the national cost sharing program relative to waivers need to be formalized. This would provide the basis for revisions to the system now and in the future (for instance, the second item below ensures that extremely bureaucratic, complicated systems are not proposed to deal with access for the poor).

- Ensure access to care.
- Maintain low cost to the facility of administration of waiver system.
- Leadership and institutional culture of ultimately existing to serve people is important to balance business and revenue interests with need to ensure all have reasonable access to health services.
- Keep decision-making decentralized (no national card system for poor or standard set of questions to determine eligibility).
- Minimize leakage, but not at the cost of freezing out the poor from access.
- Minimize loss of revenue through leakage (non-poor receiving waivers)

9.3 Changes in definitions and procedures

- There appear to be no problems with the definitions of exemptions.
- Decentralized decision-making for waivers means that there are not standard definitions, but most facilities used similar criteria for assessing: patient cannot pay bill, so there is a review of information on extended family economic situation to assess ability to pay.

9.4 Increased information to communities and individuals

The surveys indicated that much of the information about waivers and exemptions is not known by those in the communities. There is a need to identify a practical means of having information provided to communities, such as through District Health Management Teams (DHMTs), and a means of monitoring what is being done. Many of those in exemption categories and those eligible for waivers are unaware of the existence of such programs.

10. Recommendations: Application of Study for National Cost Sharing Program

10.1 Policy changes needed

- The exemptions cannot be reduced or done away with because the waiver system is so unreliable. The study shows that 33 percent of exemptions go to poor patients, and thus provide a good safeguard for some of the poor who should receive a waiver but do not.
- Some believe that either waivers or exemptions should be eliminated to minimize confusion. If exemptions were done away with, there would be a need for a stronger waiver system. Then the poor who need access to basic services would receive them regardless, while those who can afford to pay for essential services would pay and would not be exempted. However, waivers are much more difficult to administer than exemptions.
- If waivers were eliminated, the system would need to ensure that the exemption categories are adequate to cover most of the poor. This would work to minimize costs only if the exemption groups covered most of those conditions or types of people who are predominantly poor. This is not likely to be the case, however. Hence, neither can be completely done away with.

10.2 Specific improvements needed

For the exemption and waiver systems to work as planned, the following changes are required:

- Conduct a national public information campaign to advise the population on exemptions — especially for family planning, treatment of children under five, and AIDS — and also about waivers for the poor. Adequate training for health staff is also required.
- Encourage the use of social workers at provincial government hospitals to certify eligibility for waivers for the poor.
- Encourage District Health Management Boards (DHMBs) and District Health Management Teams (DHMTs) to publicize the exemption and waiver systems in their own locales.
- Keep much better records of the number and value of exemptions and waivers granted.

10.3 Future measurement of impact

- Improved recordkeeping and monitoring of waivers and exemptions would provide baseline data to do regular desk audits of the system.
- Periodic field study may be needed to validate desk studies every two to four years. The frequency is hindered by the cost of such studies.

Appendices

Appendix A

Appendix A. The History and Context of Cost Sharing in Kenya in the Non-health Sectors¹

1. Historical and Cultural Background

Cost-sharing is not a new concept in Kenya. For all practical purposes, people have always paid for some services, in the form of "contribution," for initiating local projects. Right from independence, Kenyans raised money on a "harambee"² basis to build health centers, schools, etc. The Government of Kenya's commitment to implementing the structural adjustment policies recommended by the International Monetary Fund and the World Bank was enunciated in the Sessional Paper No. 1 of 1986, Economic Management for Renewed Growth, which provided the longer-term framework within which the three subsequent National Development Plans were to be formulated.

The introduction of cost-sharing arrangements in the social service sector to increase Government revenue generated from users of services is likely to have an impact on the well-being of poor members and other vulnerable groups of the Kenyan society.

Traditionally, Kenyan communities have always been mindful of the welfare of the disadvantaged people in the society. The concept of community contribution is widely practiced and has taken into account the abilities of members of the community (the need to waive/exempt or subsidize some members of society). This form of cost-sharing is therefore an integral part of "African socialism" and is evident in the design of African social security systems.

The extended family system has been relied upon by family members to provide support whenever there is need. In the urban areas characterized by monetary economy and nuclear families, social welfare groups have emerged to assist members who are in need. Membership is usually based on the place of origin, kinship, or clanship. Funds raised through these community support groups are for multi-purpose use, ranging from school fees and medical bills to funeral expenses for their members.

At independence, the Government endeavored to provide essentially free medical care and primary education, and only introduced minimal charges. Fees were also variable, with lower fees being levied to poorer districts. In the case of health care, the token fees could be waived by hospital authorities for poor patients. Certain diseases such as tuberculosis and leprosy were exempted from fees.

In the implementation of structural adjustment policies, the Government has recognized the need to protect the poor and vulnerable groups such as those communities living in arid and semi-arid regions, drought-prone areas, and nomadic and pastoral communities. In the social dimensions of the

¹ This section was researched and written by Moses Njau of Moi University.

² "Harambee" is a Kiswahili word that roughly translates to "community fund-raising."

development program and public investment program, the Government is therefore targeting these areas for special assistance to improve residents' access to basic services.

2. Other Government Sectors

A number of other Government sectors, recognizing that some individuals cannot afford to pay for some basic services, have developed mechanisms for improving access. Some methods used by these other sectors in assessing ability to pay are similar to those in use in the health sector. These assessments are often based on occupation, household assets, and demographic information such as age, marital status, and number of dependents. Certification and authorization is often provided by local officials or social workers familiar with the area and its residents. Brief descriptions of some of these targeting mechanisms from other sectors are provided below.

2.1 Education

Parents already bear a heavy burden in educating their children at primary school level, although education at this level is supposed to be free. This is because of non-tuition fees charged at government schools (books, uniforms, etc.), or tuition and other fees at private schools. In secondary school, the level of expenditure varies according to the category of the school, for instance, whether it is a government or private school. Costs include transport, building funds, and other charges levied by Parents and Teachers Associations.

There are no waivers as such for school fees. The Ministry of Education operates a bursary fund that is given to schools on the basis of each school's estimated needs. Those interested in a bursary are required to fill out an application. The information required on the form includes parents' nationalities, occupations, number of siblings and their ages and occupations, including number of children in school. Sources of family income are also required. This includes income to parents, guardian(s), and any working brothers and sisters. Finally the total amount of school fees for brothers and sisters is asked for in order to assess the burden of education expenses on the household.

The information provided by the applicant is validated by writing to the Children's Department of the Ministry of Home Affairs in the home district of the applicant. The department investigates and provides the school with information that guides the decision on individual cases.

The decision as to who receives funds and how much they receive is reached at the school's Board of Governors meeting by a team comprised of the head teacher, the local District Officer, and the District Education Officer representing the Ministry of Education. For desperate cases the head teacher may decide and make recommendations to the Board of Governors for award.

2.2 Water Supply

Cost sharing in the water sector exists in development and recurrent forms. In development, communities have been contributing in the form of cash, labor, and materials; in recurrent form, water users are sharing costs through payment of water charges.

Government policy statements reveal three important policy stances: (1) everybody will pay for water; (2) charges for urban water consumers will be such that they cover capital, operational, and maintenance costs, while for rural water users the charges will cover only direct operations and maintenance costs; and (3) notwithstanding the above two policy positions, the consumer's ability to pay will be taken into account so the poor will not be denied water services.

Historically, up to 1981, there were tariffs — differentials among discrete communities in various parts of the country — charged according to meter reading. But in 1981, the President of Kenya decreed that the rural water consumers should be charged a flat rate of KSh. 15 per month.³ This was revised further, and currently rural water tariffs reflect five different methods of charge depending on whether consumption is metered or not, and the monthly consumption.

Waivers are not normally based on individuals' applications but rather on identified need for specific categories of people or circumstances. However, the Government continues to subsidize various water supply schemes.

Data for 1986 reveal that the direct cost of operating and maintaining water supply schemes by the Ministry of Water Development was KSh. 32 million, while revenue earned from them was only KSh. 20 million. The shortfall would normally reflect the level of direct Government subsidy to consumers, although they purchase their water from Ministry of Water Development.

The Government recognizes that the major responsibility for the production and distribution of water remains with the Government since many in society cannot afford the full cost of water and sewerage systems. In areas where communities can afford these systems, there are metered connections to households individually, but where affordability is low, communal facilities are provided. Even where the operation and maintenance of water supplies is the responsibility of the local authority, imposition of water tariffs is subject to approval by Ministry of Water Development and must be gazetted.

2.3 Social Services

The department of Social Services in the Ministry of Culture and Social Services runs a social welfare program. This is intended to take care of some basic needs of the destitute children and the aged. Assistance is given mainly to cover education, including school fees, rehabilitation and retraining of

³ As of April 1995, when this report was written, KSh. 42 was equal to US \$1.

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adults, improvements of homesteads, and care for orphans and the aged. Currently, direct support is being discouraged in favor of eliciting more support from relatives.

The department administering this program in the district is headed by District Social Development Officer who supervises staff responsible for the social welfare functions of the department. There are also Community Development Assistants (CDA) who are employees of local authorities but work for the Department of Social Services. They are recruited and stationed locally.

CDAs, with the help of local leaders, carry out casework investigations that examine the family background of each case and gather basic information to assess the case. This information includes names of immediate members of the family and other relatives, their addresses and current residence, their occupations, sources of family income, size of the family, and other social economic information.

The final decision to give assistance rests with the social welfare committee which reviews cases that have been recommended for assistance by CDAs. This committee is comprised of a Social Welfare Office and representatives of various NGOs. The decision of this committee remains final without further deference to the headquarters.

2.4 Agriculture

The purpose of cost-sharing in this sector is to raise revenue for funding such activities as research and extension services (i.e., practical help for farmers: soil testing, how to get a higher yield, etc.) as a means of increasing agricultural production through intensification. Cost-sharing measures being implemented in the agricultural sector are mainly in areas where benefits accrue directly to individuals. These include farmers' training, fertilizers, seeds, tractor-hire services, livestock dipping, artificial insemination, and veterinary services. The Government is also shifting from price controls on agricultural products towards greater dependence on market forces.

There are no individual waivers or exemptions as such, except in special circumstances, e.g., during drought/famine. The Government realizes that cost-sharing will impact vulnerable groups at both the level of production and in the marketplace through price increases. The Government provides subsidies through the Marketing Board's purchases of produce and sales. In addition the Government targets its assistance to vulnerable groups by providing famine relief, inputs, and services to deficit areas without charge. A committee under the Provincial Administration determines who is eligible for assistance.

2.5 Electricity

In order to improve access to electricity in low-income urban areas, The Kenya Power and Lighting Corporation differentiates its charges based on consumption levels; that is, low-usage customers pay a lower unit charge than large consumers, since low-level users are also likely to be poorer. Therefore, the charge per unit is graduated as the usage amounts increase. Another factor in determining rates is the economic level of the community (e.g., poorer urban areas pay lower unit charges than richer areas).

In addition to this built-in system which accommodates all classes of domestic power consumers, the Company also differentiates its standing charge per meter by location within the urban area. In Nairobi, for example, a consumer in a middle-class residential estate pays a higher standing charge than a resident of a lower-class residential area.

3. Non-Governmental Organizations

There are two primary church organizations operating in the health sector: the Christian Health Association of Kenya (CHAK) and the Kenyan Catholic Secretariat (KCS). These umbrella associations represent Protestant and Catholic health facilities in the country that provide preventive and curative care. These organizations have an advisory and coordination role, as well as organizing training programs for health workers of the associations' member institutions.

Neither CHAK nor KCS has a policy on how the member hospitals should deal with the poor who seek health care in their institutions. As Christian organizations, however, they are encouraged to be compassionate and not deny care to those who are in need. The result is a policy of maintaining fee levels as low as possible to ensure that members of the community may receive care. The fees of these institutions tend to be substantially higher than government facilities, however.

It is an important issue because many of the mission hospitals are situated in very poor rural areas where the communities are disadvantaged. But the fees and system for waivers for the poor vary by facility without any consistency among the church health facilities. In some hospitals, charity funds have been established to pay fees for poor patients who cannot pay their bill. Another method has been subsidization. For example, to promote community-based primary health care services, most church facilities provide the services and charge a fee well below cost to encourage use of these services. Other facilities seek donations for their general operating expenses from the communities they serve and from foreign donors for specific projects or equipment. Some of their health care services are provided below cost and have to be subsidized by donations. Some hospitals seek to obtain sponsors for specific groups of patients, such as diabetics or those with chronic conditions that require large expenditures of money over time.

Appendix B

Health Care Financing Programme

USER FEES AT MINISTRY OF HEALTH INSTITUTIONS

1st October 1994

NOTES:

- (1) Non-Kenyans pay double the stated fee for all services.
- (2) NS = No service of this type provided by this level of facility.
- (3) A separate fee schedule exists for Kenyatta National Hospital.

| SERVICE | CONDITIONS | PROVINCIAL GENERAL HOSPITALS | DISTRICT AND SUB-DISTRICT HOSPITALS | HEALTH CENTRES |
|---|---|------------------------------------|---|-------------------|
| GENERAL WARD | PER DAY - MAX 14 DAYS | 40/- | 30/- | 10/- |
| MATERNITY WARD | PER DAY AFTER DELIVERY - MAX 14 DAYS | 40/- | 30/- | 10/- |
| PAEDIATRIC WARD | PER DAY - MAX 14 DAYS | 20/- | 10/- | none |
| AMENITY WARD - SINGLE ROOM | PER DAY - NO MAXIMUM NUMBER OF DAYS (Listed fees are guidelines only) | 400/- | 400/- | NS |
| AMENITY WARD - DOUBLE ROOM | PER DAY - NO MAXIMUM NUMBER OF DAYS (Listed fees are guidelines only) | 300/- | 300/- | NS |
| OUTPATIENT TREATMENT | PER TREATMENT (For each drug, injection, dressing etc received) | 30/- | 20/- | 10/- |
| THEATRE | MAJOR SURGERY (General anaesthesia) | 150/- | 100/- | NS |
| | MINOR SURGERY (Local anaesthesia - includes male circumcision) | 80/- | 50/- | 50/- |
| DELIVERY FEE | PER DELIVERY (PLUS daily Maternity Ward fee as above; Caesarian sections charged as major surgery) | 100/- | 80/- | 40/- |
| LABORATORY | PER EXAMINATION (see separate fee list) | | | |
| | A. Simple Tests | 20/- | 20/- | 20/- |
| | B. Intermediate Tests | 40/- | 40/- | 40/- |
| | C. Specialized Tests | 60/- | 60/- | 60/- |
| X-RAY | PER EXAMINATION | See Attached Fee Schedule | | NS |
| PHYSIOTHERAPY, OCCUPATIONAL THERAPY (Ministry Patients) | PER DAY - MAX CHARGE KSHS. 200 PER MONTH | 20/- | 20/- | NS |
| PHYSIOTHERAPY, OCCUPATIONAL THERAPY (Private Patients) | PER DAY - NO MAXIMUM | 150/- | 100/- | NS |
| DENTAL | Separate Fee Schedule | | | |
| WORKMAN'S COMPENSATION | Separate Fee Schedule | | | |
| MEDICAL EXAMINATION | PER EXAMINATION | 100/- | 100/- | 100/- |
| MEDICAL CERTIFICATION | PER CERTIFICATE | 100/- | 100/- | 100/- |
| CIRCUMCISION | PER OPERATION | 80/- | 50/- | 50/- |
| MORTUARY | PER DAY | 100/- | 100/- | NS |

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Appendix C

Ministry of Health, Government of Kenya
Health Care Financing Programme

EXEMPTION RULES FOR MINISTRY OF HEALTH INSTITUTIONS
1 October 1994

NOTES:

1. In the case of financial hardship, patients should be considered for a waiver according to laid down procedures.
2. There are no exemptions from inpatient fees for NHIF beneficiaries. A claim should be submitted for all NHIF beneficiaries, even if the patient is exempt under any of the following rules.

EXEMPTION RULES:

1. *Exempt patients* – The following groups of patients are exempted from paying Facility Improvement Fund fees of all types except where indicated otherwise:

- children 5 (five) years of age and under (Outpatient fees only)
- inpatients readmitted for the same episode of illness within 14 days of discharge;
- patients from charitable and destitute homes and from homes for mentally handicapped;
- prisoners and all other persons in police custody;
- unemployed persons who present written certification by their District Officer (valid for six months, after which certificate must be renewed).

2. *Exempt outpatient services* – Outpatients seen at any of the following outpatient clinics are exempt from outpatient treatment, laboratory and x-ray fees:

- family planning;
- ante-natal and post-natal clinic;
- child welfare clinic – also exempt by virtue of age;
- STD clinic.

3. *Exempt illnesses* – Patients with any of the following illnesses are exempt from any Facility Improvement Fund fee related to treatment and follow-up of their primary illness. This exemption includes outpatient services, inpatient services, and necessary investigations for the following illnesses:

- antenatal complications of pregnancy
- tuberculosis (TB) and leprosy
- AIDS

NOTE: Patients with other chronic diseases (EG., psychiatric illness, diabetes, epilepsy, asthma) and emergency cases (eg., RTA) are NOT automatically exempt. For financial hardship cases, fees should be waived following the laid down procedures for long-term waivers for the chronically ill.

4. *Exempt inpatient services*

- After 14 days inpatients are exempt from daily inpatient charges, but NOT from x-ray or laboratory fees. There is no limit on the number of chargeable inpatient days at KNH.
 - "Downward" referrals of inpatients from KNH, provincial hospitals, and district hospitals for recuperation (with supporting documentation from the referring facility);
 - For "upward" referrals of inpatients to provincial, district, and subdistrict hospitals (but not KNH), the maximum number of inpatient days charged includes the inpatient days at referring hospital and at the receiving hospital;
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Appendix D

Appendix D. Bibliography

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