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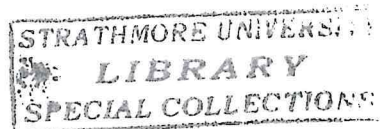
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**CHALLENGES FACING THE IMPLEMENTATION OF MANAGED
HEALTHCARE IN PRIVATE HOSPITALS IN KENYA: A CASE OF AVENUE
HEALTHCARE**

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MBA HCM 88846/16



**SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS OF MASTER OF
BUSINESS ADMINISTRATION-HEALTHCARE MANAGEMENT AT
STRATHMORE BUSINESS SCHOOL, NAIROBI**

2019

DECLARATION

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person.

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ABSTRACT

MHC has confirmed the capability of eliminating surplus medical expenditures and improving the effectiveness as well as the quality of medical care delivery specifically in the USA. However, despite the existence of MHC for a number of years, the concept is yet to fully take root in developing countries in Asia and Africa, where out of pocket payments make the greatest percentage of healthcare financing. In Kenya, health insurance represents less than 20% of the total insurance premiums and statistics indicate less than 10% of all healthcare finances are subjected to risk pooling through health insurance.

This study examined the challenges encountered in the implementation of MHC in private hospitals in Kenya. The study was carried out at Avenue Healthcare in Nairobi County and involved the medical workers at the facility. The study was anchored on the Kutzin descriptive framework and the traditional indemnity model, and employed a cross-sectional descriptive design. The population was made of the 9 Avenue Healthcare Centers in Nairobi County and the unit of analysis was the 104 medical workers in these centres.

This research used primary data, collected using a self-administered questionnaire developed based on the constructs of the literature review. The collected data were then analysed using descriptive and inferential statistics. The findings established that health workers' attitude affects implementation of MHC in private hospitals within Kenya and that there must be profound commitment and support by health workers for smooth implementation of MHC. The study also found that there is poor health workers' knowledge of the concept. The results show that the major costs drivers for MHC (MHC) programs are: administrative; operational, set-up, marketing and training. The regression results revealed a positive and statistically significant relationship between health workers' knowledge and attitude, costs of and implementation of MHC. The study concluded that implementation of MHC in private hospitals in Kenya is significantly influenced by health workers' knowledge and attitude and costs. The study recommends that the management of private hospitals in Kenya should involve medical workers in planning and implementation of MHC programs, develop training and development programs and ensure training is carried out frequently on MHC programs prior to implementing the programs.

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DEFINITION OF KEY CONCEPTS AND TERMS

- Attitude** - Attitudes are positive or negative assessments that an individual has on objects, concepts or living things.
- Costs** - Cost is money paid for the provision of healthcare services, including the costs of procedures, therapies and medication.
- Knowledge** - Knowledge is the level of awareness or sensitivity of the MHC programs.
- MHC** - MHC refers to a comprehensive list of healthcare benefits and services covered while employing the use of fiscal incentives to persuade the physicians and the patients to go after medical plan procedures and set rules in a cost effective manner.
- Medical workers** - Medical workers are health professionals whose duty is to maintain or improve health through the prevention, diagnosis and treatment of diseases, conditions, injuries and other physical and mental disabilities in humans

ABBREVIATIONS

CI	- Confidence Intervals
CMS	- Child Medical Services
EPO	- Exclusive Provider Organization
FBO	- Faith Based Organizations
FFS	- Fee For Service
FGD	- Focus Group Discussion
GoK	- Government of Kenya
HCV	- Hepatitis C Virus
HMIS	- Hospital Management Information System
HMO	- Health Maintenance Organizations
KIPPRA	- Kenya Institute for Public Policy Research and Analysis
MHC	- Managed Health Care
NHIF	- National Health Insurance Fund
OOP	- Out-Of-Pocket
PPO	- Preferred Provider Organizations
SD	- Standard Deviation
SPSS	- Statistical Package of Social Sciences
UHC	- Universal Healthcare Coverage
USA	- United States of America

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Healthcare financing has received significant studies and policy awareness in the developed nations as well as the developing nations. The main concern is how to attain adequate funds so as to finance healthcare requirements for all people (Ataguba, 2010). Proper healthcare financing ensures the population not only has access to healthcare but also uses the health services when needed (Jenkins, *et al.* 2011). Globally, it has been recognized that how the health systems are funded extensively determines whether individuals get the required healthcare and if they undergo monetary hardships due to obtaining the much needed healthcare services (Carapinha, *et al.*, 2011). Developed due to the ever-increasing costs of healthcare and the dysfunctional uneven services, MHC (MHC) entails an array of activities carried out in diverse managerial surroundings (Carapinha, *et al.*, 2011). By laying emphasis on measures to keep clients in good health through malady prevention interventions, curative measures and overall healthcare promotive services, MHC providers reduce their costs (Onoka, 2014). They are thus structurally a transformation from the traditional healthcare indemnity procedures (Andersen, Rice & Kominski, 2011). The Kutzin descriptive framework indicates that the aim of health funding is to avail funds and establish the appropriate structures of financing to providers with the aim of ensuring ease of access to effectual healthcare, be it public or private public (Kutzin, 2013).

Developed in USA as a response to the spiralling health care costs, MHC is not an isolated activity but a range of deeds undertaken in array of managerial surroundings (Fairfield, *et al.*, 1997). To date, many nations are turning to rivalry among the MHC schemes so as to make trade-offs between healthcare expenditure and healthcare quality. In USA, the main public schemes and various private health indemnity schemes provide enrolees with an option of MHC schemes compensated by capitation (Frank, Glazer & McGuire, 2000). In Africa, most countries finance their healthcare with revenues from tax, however, poor government revenue collecting systems push them to seek alternative sources of revenue to augment the deficit (Onoka, 2014). Most African nations end up relying on out-of-pocket (OOP) payments for healthcare services, though addition assistance from joint and

multiparty stakeholders is noted most health ministries in Africa end up attending numerous seminars to respond to the stakeholders inquires and not in coming up with longstanding solutions for their citizens (Kaseje, 2006). In Kenya, universal healthcare coverage (UHC) is one of the government focus areas under the “Big Four” agenda. UHC captures the population covered, the services provided and the cost of services provided. The GoK aims to achieve this through scaling up the National Health Insurance Fund (NHIF), thus increasing insurance coverage and achieving 100% cover of the poor (KIPPRA, 2018). To date however, health indemnity in the country is very low and entails both voluntary and involuntary insurance plans (Kihuba, *et al.*, 2016). The coverage of health indemnity is higher within the metropolitan population (19.7%) as compared to the countryside population (7.4%); and among the richest (26.4%) as compared to the poorest population (1.9%). Advancement towards widespread healthcare access through NHIF is still a herculean task (Muiya & Kamau, 2013).

MHC refers to a comprehensive list of healthcare services deployed in a cost effective manner (Navarro & Cahill, 2009). Maynard and Bloor (1998), viewed it as the policies and processes implemented by healthcare providers that cause a shift, making them cost makers and managers as opposed to cost takers seen in other forms of health indemnity. This therefore calls for them to aggressively monitor the actions of both the health service provider or doctor and the patient with an aim of controlling cost (Rivoet *et al.*, 1995).

The fundamental logic behind MHC for a group of people is to place the monetary risks onto healthcare indemnity providers and organizations to offer incentives in resource use (Fairfield *et al.*, 1997). With managed care, quality healthcare services are provided in a manner that is cost efficient (Awosika, 2005). The managed care incorporates the compensation and delivery of healthcare services and products to customers in an attempt of delivering the maximum service quality at the least cost possible (Navarro & Cahill, 2009). Managed care entities organize every form of the delivery scheme so as to direct all the expenses in the scheme (Margolin, 2011). Various forms of managed care exist that may include the preferred provider organizations (PPO), the health maintenance organizations (HMO) and also the exclusive provider organization (EPO) (Scutchfield, Lee & Patton, 1997). The PPO is a type of managed care where the indemnity firm agrees to

contract with a choice set of providers to compensate them on the basis of economical fee for service as is (Frank, Glazer & McGuire, 2000). The EPO provides a system of providers that are contracted to offer services on economical basis and thus enrollees normally do not require referrals for the services provided by the network providers. On the other hand, HMOs entail prepaid payment, narrow panels of providers and postulation of fiscal risks on the providers' part (Wagner & Kongstvedt, 2007). Various ways of paying for provider services in MHC setting exist, these include capitation, co-payment, coinsurance, deductibles, economical fee for service and the fee for service compensation (Dymowski, 2010). Capitation entails a payment system in which healthcare providers receive fixed payments per month/year on a member, irrespective of the visits made. While coinsurance will entail an indemnity strategy provision in which both the insurer and the insured person share the covered charges in a specific ratio (Margolin, 2011). Co-payment involves a cost sharing agreement in which the enrollee of MHC pays a specific even amount while deductibles entails the amount requisite to be compensated by the insured under a medical indemnity agreement before the paybacks become allocated (Frank, Glazer & McGuire, 2000). The economical fee for service entails a decided service rate between the payer and the provider that is generally lower than the provider's full charge but the fee for service compensation includes recompense in definite amounts for detailed services offered (Navarro & Cahill, 2009).

Healthcare schemes in Kenya can be grouped into three sub-systems: the public segment; the commercial private segment; and the faith-based organizations (FBOs). Public segment is the leading in requisites of healthcare facility numbers, followed by the commercial private segment and the FBOs. Healthcare facilities are efficient in levels running from level 1 (dispensary which is the least care level) to level 6 (referral hospital which is the uppermost level of care) (Munge & Briggs, 2013). Wanting quality of services of the public segment offering, leads Kenyans progressively to look for more in private sectors (Okech & Gitahi, 2012).

Private sector healthcare in Kenya includes all the offers outside the public segment. It constitutes both not-for-profit and for-profit firms, such as FBOs and non-governmental organizations (NGOs). The private segment covers an extensive array of healthcare

services, for instance nurses, doctors, pharmacists, midwives, and clinical officers, (Barnes et al., 2010).

The private medical segment in Kenya is progressively gaining popularity for meeting the increasing demands in funding and quality service delivery. More than half of the health amenities in Kenya are privately owned, and 37 percent of all medical expenditure occur in private amenities (Pyone, Smith & Broek, 2017). For the last 20 years, the private medical segment in Kenya has revealed considerable growth and Kenya's private medical segment is one found to be greatly developed in Sub-Saharan Africa. The private health market in Kenya includes: commercial hospitals and clinics, nursing and maternity homes, academic centres and university hospital, pharmacies and drug shops, private laboratories and other diagnostic services (Barnes et al., 2010). Presently, the private healthcare schemes, when contrasted with the social schemes, reports the biggest share of entire healthcare funding (Turin, 2010).

1.1.1 Avenue Healthcare

With its headquarters in Nairobi, Avenue Healthcare specializes in reasonable, high quality medical services, with various amenities. The group consist of: 2 Avenue Hospitals in Nairobi and Kisumu, Avenue healthcare out-patient clinics, Avenue rescue (provides ambulance services and urgent situation medical technical courses), Avenue home-care, which focus on provision of nurse aides under care of competent nurses at home, rental of medical kit and training of nurse aide (Avenue Group, 2018).

Avenue healthcare is Kenya's only health maintenance organizations (HMO) specializing in medical schemes with benefits of both in and out-patient. It provides reasonable improved quality health services in the market on the basis of regulations of managed provider based healthcare. This type of pooling risk cancels the needs for costly intermediaries, by enabling the medical providers a repository for the funds pooled. Avenue healthcare therefore was the most conducive source of research for this study

1.2 Problem Statement

MHC has established the capability of eliminating excess health service costs as well as improving the quality and efficiency of service delivery in healthcare facilities (Dymowski, 2010). However, it has been noted, more so in the US, to have resolved some challenges and augmented others (Maynard & Bloor, 1998). This further highlights the inconsistencies in the research on MHC settings and their implantation. Further, despite its existence for several years, the concept is yet to take root in Asia and Africa where the regressive out-of-pocket (OOP) payments forms the greatest percentage of healthcare financing (Munge & Briggs, 2013).

Health insurance represents less than 10% of the total insurance premiums in Kenya and statistics indicate that less than 4% of all the medical funds are subjected to risk pooling (Okech & Gitahi, 2012). Evidently, Kenyans heavily depend on OOP payments, which are charged and payed for at the service point in both private and public healthcare facilities (Chuma & Okungu, 2011). Identified as the main source of healthcare financing, OOP limits access to healthcare services and has led many to financial impoverishment (Munge & Briggs, 2013). Empirically, a number of studies have explored the concept of MHC and the challenges of healthcare financing in various countries. For instance, in South Africa, Kinghorn (1996) assessed the influences of MHC in the private healthcare segment and concluded that MHC alone cannot be seen as a solution to private sector financing. Onoka (2014) assessed the role of health maintenance organizations in Nigeria and revealed that the private sector stakeholders and the healthcare situation greatly influenced policy making and implementation of HMOs. Onoka (2014) however did not highlight the challenges that faced the HMOs as they implemented managed care.

In Kenya, Munge and Briggs (2013) analysed the improvement of healthcare funding and concluded that in overall healthcare funding schemes were regressive and OOP payments were regressive. However, they failed to highlight the existence of managed care in Kenya. Kamau, Onyango-Osuga and Njuguna (2017) studied the challenges of referral schemes for quality healthcare services in Kiambu County and concluded that infrastructure, healthcare workers' capacity, and financial resources are the key stumbling blocks in successful implementation of the healthcare referral system. The reviewed studies

acknowledge that healthcare financing systems are in the developing world notoriously challenging to conceptualize and dwell more on OOP payments despite the existence of medical insurance. Very little is highlighted on managed care systems, its merits and demerits, and their effects on healthcare service delivery. Furthermore, the concept is yet to be fully embraced by private sector healthcare service providers. With its success in developed countries, more so in the US where it stems from, questions arise on the challenges facing implementation of MHC in private hospitals more so in Kenya.

1.3 Research Objectives

The key aim of this research was to establish the challenges facing the implementation of MHC in private hospitals in Kenya with focus on Avenue Healthcare Group.

1.3.1 Specific Objectives

- (i) To establish how health workers' attitude affects implementation of MHC in the private hospitals within Kenya.
- (ii) To examine how health workers' knowledge on MHC influences the implementation of MHC in private hospitals within Kenya.
- (iii) To assess how costs of MHC influence the implementation of the program in private hospitals in Kenya.

1.4 Research Questions

- (i) How does the attitude of health workers affect the implementation of MHC in private hospitals in Kenya?
- (ii) How does the knowledge of health workers on MHC influence the implementation of MHC in private hospitals in Kenya?
- (iii) How do costs of MHC affect the implementation of MHC in private hospitals in Kenya?

1.5 Significance of the Study

The results of this dissertation will be of significance to the management of both private and public medical facilities in Kenya. The findings will help to determine the key challenges to MHC implementation and maybe used to as a tool to help fashion the

necessary policies. Avenue Healthcare management team may use the study findings and recommendations to communicate the different challenges affecting the performance of MHC programs to its stakeholders.

Additionally, the findings will be of significance to policy making institutions and the GoK to come up with policy mechanisms of health financing using the MHC concept, which is yet to take root in Kenya despite its success in other countries. The government may also use the study findings and recommendations to set up a legal framework on MHC in Kenya.

Finally, the study findings will add on to the empirical and theoretical literature on MHC and open up areas, which may require additional research. The study will also suggest areas for further research, which prospective scholars and research may build on to carry out their studies.

1.6 Scope of the Study

The research was carried out at Avenue Healthcare facilities in Nairobi County and involved the medical workers. Avenue healthcare is the pioneer and the only private health facility that offers the MHC services in Kenya, thus it was ideal for the study. The study focused on the attitude of health workers, health workers knowledge and costs of MHC as the independent variables and implementation of MHC as the dependent variable.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This section focuses on theoretical literature review, which entails a review of various theories which expound on MHC. The chapter also reviews international studies on MHC, and presents the theoretical structure of the study. A summary of reviewed literature is then provided.

2.2 Theoretical Review

This study was anchored on the Kutzin descriptive framework and the traditional indemnity model as the key theoretical considerations.

2.2.1 The Kutzin Descriptive Framework

This descriptive framework was developed by Kutzin (2001) and is grounded in the globe medical report of 2000, which explained health funding as part of the four roles of the medical structure (Kutzin, 2013). The framework is appropriate to all healthcare funding systems as it calls for scrutiny of healthcare financing and resource allocation (Hort et al. 2010). The framework differentiates the functions of health funding systems, and leans on medical economics perceptions in the consideration of market structures for health indemnity (Onoka, 2014).

According to the framework, healthcare funding consists of three main sub-types: collection of revenue; pooling of collected funds; service purchasing for those in the pool and also considers the policies governing the benefits of those in the pool (Kutzin, 2008). Revenue collection refers to the process of obtaining funds whose sole purpose is healthcare funding from households. Pooling ensures gathered funds are managed in a manner that cushions those in the group and allows for risk sharing for its members. In the procuring process, the pooled finances are paid to the providers so as to offer timely quality medical interventions (Chuma & Okungu, 2011).

The Kutzin framework also encompasses rules relating to health service coverage (Alkhamis, Hassan & Cosgrove, 2014). The way through which the agreed upon policies are implemented may grossly affect: equity in healthcare financing; healthcare service

access; and even administrative effectiveness (Thomson, Foubister & Mossialos, 2009). Healthcare financing is pivotal in driving protection against financial catastrophe through spreading the risk among those in the pool. The funding policy objectives are therefore important in healthcare systems (Hort *et al.*, 2010).

2.2.2 The Traditional Indemnity Model

The traditional indemnity model entails the traditional insurance plans where the insurer pays a certain percentage of health services rendered and the member incurs the remaining costs (Andersen, Rice & Kominski, 2011). The insurer undertakes the cost of health services rendered to the insured by selected healthcare providers. Here the risk of healthcare costs is laid upon the insurance company. The patients select the providers from a given panel, the providers subsequently bill the indemnity firm who settle the cost on a fee for service or as per case basis (Wagner & Kongstvedt, 2007). Indemnity firms may employ monetary hindrances to limit missuses by those it covers, through co-payments, and deductibles (Sekhri, 2000). This model deals primarily with curative healthcare service provision, in most cases leaving behind promotive and preventive healthcare services. The indemnity firm also determines the percentage of cost it would cover for various services and tests leaving the insured to cover any cost above that which it stipulates in the initial agreement (Wagner & Kongstvedt, 2007).

These traditional indemnity schemes encourage medical indemnity to be efficient by way of a fee for service dimension (Andersen, Rice & Kominski, 2011). They are, however, not cost effective and the co-payments and deductible features are regressive and raise OOP costs for the insured (Wagner & Kongstvedt, 2007).

2.3 Empirical Review

The implementation of healthcare financing strategies faces numerous challenges and statistics show that strategies fail more than they succeed (Kgasi, 2010). MHC may lead to obstacles which lower the access of proper care through: hidden restrictions on profits, perverse limits on provider choices and complex technical needs (Awosika, 2005). The operation of managed care tactics follow a sequence of measures for controlling costs that include prepaid medical schemes, potential systems of payments as well as fee programmes

(Kgasi, 2010). A number of studies have explored the concept of MHC in various countries both in the developed and developing countries. The MHC concept emanated from the United States hence most studies have been carried there and they explored the effect on MHC on various types of ailments.

2.3.1 Health Workers Attitude and the Implementation of MHC

In the United States, the providers usually complain about unsound decrease in reimbursements, inequitable labour practices and disreputable interferences by health schemes into medicine practice (Sekhri, 2000). The health workers' perception of the healthcare financing strategy greatly affects the implementation of the organizations financing plan in terms of both the pace and the efficiency. For any health financing strategy to succeed in implementing a strategic plan, there must be deep commitment on the part of the top management and the support to health worker and to bring them along to ensure that they are part of the plan (Dymowski, 2010).

In South Africa, a study by Hattingh (2015) assessed the moral challenges in managed care. The study observed that healthcare experts working in managed care are mainly covered with conflicts, vis-à-vis incongruence among the ethical regulations from their professional bodies and the legislation concerning the managed care. The study concluded that common perceptive of the claims and tasks of each of the stake-holders might support a more consistent, sustainable healthcare scheme.

In their study, Simon, *et al* (1999) carried out a survey on the views of MHC among residents, students and deans at schools of medics in United States through telephone interviews. The findings established that the respondents showed feelings towards the managed care were negative, with a range of a low mean (\pm SD) score of 3.9 ± 1.7 for the residents to a high of 5.0 ± 1.3 for the deans. The research also revealed that the respondents indicate that the fee for service (FFS) medicine was better rated than the managed care in stipulations of access, lessening the moral conflicts and the superiority of the doctor-patient association. The study made conclusions that negative scrutiny of managed care was extensive among the residents, medical students, and deans of medical school.

In Kenya, Pyone, Smith and Broek (2017) assessed the performance of free maternity service policies and its connotation for medical scheme control in the country through a qualitative research and a sample of 39 key stakeholders from six counties in Kenya. The study found that health worker attitude on new policies, weak enforcement mechanisms and misaligned incentives led to weak policy performance of free maternity service policies in the country and further complicated by the concurrent devolution of the health system.

Another study by Nzioki, Onyango and Ombaka (2015) examined the competence and factors affecting the competence of social health schemes in the provision of motherly and child medical services in Mwingi District, Kenya. The study adopted a qualitative study and sampled fifteen key informants. The findings revealed that the factors affecting the efficiency of CHS in the provision of MCH services included health workers' attitude, challenges that face social medical staff, social-cultural factors as well as economic factors and lack of motivation among community medical workers. The study recommended that to advance the competence of CHS in Mwingi, the challenges that face CHWs and social-cultural and financial factors that affect the effectiveness of the CHS in the district have to be looked upon.

2.3.2 Health Workers Knowledge and Implementation MHC

Inadequate medical literacy has been connected to troubles with the use of health financing services, (Wolf, Gazmararian & Baker, 2005). According to Dymowski (2010) for the managed care plans to be thriving in other groupings, is for health worker's education with consideration on health effectiveness, as contrasting to a logic of care entitlement that could may have developed under state medical forms. In Kenya for instance, there is limited knowledge by health workers about healthcare financing strategies, which is proving detrimental to achieving the desired impact and the realization of the highest possible standards of health for all (Kimathi, 2017). Need for employee competence, abilities and skills is also cited as a barrier to implementation of strategies. Whenever an organization intends to implement new processes or technology, it must dedicate itself to affecting the necessary skills on the employees to enable them to perform (Awosika, 2005).

A study by Kgasi (2010) explored the duties of a case director in an organized care firm. The study adopted a quantitative explanatory study in exploration of insights of case directors in regard of their functions. The study collected data using a self-administered questionnaire and sampled 25 respondents. The results established that majority of case directors had the know-how of their tasks and expectations but they actually incident various forms of barriers. The study concluded that there is appearance of uncertainty with some respondents in regard of definite forms of their function.

In addition, Wolf, Gazmararian and Baker (2005) evaluated the association between health literacy, self-reported physical and mental health functioning, and health-related activity limitations among new Medicare managed care enrollees. The study conducted a cross-sectional survey of 2923 enrollees in the United States. The study found that individuals with inadequate health literacy were more likely to report difficulties with instrumental activities of daily living. The study concluded that among community-dwelling older adults, inadequate health literacy was independently associated with poorer physical and mental health.

Baker et al (2002) also studied the practical medical literacy and the risks of admission in hospitals among Medicare managed care enrollees. The study sampled a likely group of 3260 Medicare directed care enrollees. The findings establish that the attuned comparative risks of admissions in hospitals was 1.29 (95% CI=1.07, 1.55) for persons with insufficient literacy and 1.21 (95% CI=0.97, 1.50) for those having directive literacy. The study made conclusions that insufficient literacy was an independent factor of risk for hospital admission among elderly managed care enrollees.

In their study, Drusset *al.* (2002) studied the degree and connections of intellectual healthcare measures of performance in the medical company data group. The study sampled 384 health maintenance firms. The study found that the imply rate of intellectual healthcare performance was 48.0%, contrasted with 69.2% for non-mental healthcare areas. In multivariate models adjusted for plan characteristics, scores for worse quality of non-mental-health domains, failure to present data openly, and low medical loss ratio all forecasted poor intellectual healthcare performance. The study concluded that improved

universal medical care, reporting transparency, and financial resource commitment to medical care forecasted improved psychological healthcare performance for U.S. HMOs.

Gazmararian et al (1998) carried out a study on medical literacy among the Medicare enrollees in a directed care firm. The paper used a cross-sectional survey and sampled 3260 fresh Medicare enrollees of 65 years of age or older were interrogated personally from June 1997 to December of the same year. The study found that 33.9% of English speaking respondents and 53.9% of Spanish speaking respondents had insufficient medical literacy. The pervasiveness of insufficient or insignificant practical medical literacy amid English speakers arrayed from 26.8% to 44.0%. The research concluded that aged directed care enrollees could not have the literacy competence required to perform sufficiently in the healthcare setting.

Finally, in Kenya Gikonyo (2011) studied the challenges facing implementation of public healthcare financing strategies in the country. The research implemented a case of research study design to investigate plan within the Ministry of Medical Services. The study found that organizational system and procedures, culture and traditions, technology, leadership, human resources and funding were the main challenges faced in the implementation of public healthcare financing strategies in the Kenya but the legal framework was not a major challenge faced in the implementation of public healthcare financing strategies in the Kenya.

2.3.3 Costs of MHC and the Implementation of MHC

The idea of directed care organizations is to be engaged in medical decisions that are as well described as decision concerning costs (Kgasi, 2010). However, MHC involvements may lead in raised costs of medical plans, if the managerial costs on the implementation MHC does not lead in matching expenditure benefits through additional of care effectual provisions (Maynard & Bloor, 1998). Familiarity with directed care in U.S. reveals that there has been a soaring intensity of surplus exploitation in our scheme, and that the function of directed care attitudes can be successful in reducing the health costs with no quality loss (Dymowski, 2010).

A study by Kimama (2011) studied the challenges encountered while implementing systems of hospital administration information in Nairobi based hospitals. The paper adopted a survey design and data collection was done through a questionnaire. The results of the research indicates that many hospitals adopted various customs in their HMIS functioning but they face a number of challenges including support from the workers, fiscal resources, in house communications, user training, methods of restructuring as well as length processes of procurement.

Davis *et al.* (2011) explored the unswerving financial saddle of chronic hepatitis c virus in a U.S. administered care population. The study evaluated the use as well as the costs of health services and treatment medicine over a 12-month time post identification. All estimates of cost were made using multivariate widespread linear sculptures in adjustment of extra variances and covariates general in healthcare data cost. The study concluded that chronic hepatitis c virus is a costly ailment to the directed care firms and the disease connected costs in hepatitis c virus surpass all cause costs in the demographically coordinated controls. The study concluded that improved efforts in the screening of HCV as well as early treatment, mainly before development to liver cirrhosis might head to saving costs in long term for the hepatitis c virus administration for directed care schemes.

Kim *et al* (2009) conducted a research on the costs of atrial fibrillation in U.S. directed care firms. The study adopted a group study and made use of claims data obtained from the Integrated Healthcare Data Schemes National Directed Care Benchmark Database January 2005 to December 2006. The study concluded that general costs of atrial fibrillation in the US directed care firms are high and the expenses are mainly because of in-patient expenses. The study recommended that an enhanced strategy of disease managing reduces atrial fibrillation linked hospitalizations and lessening of the general burden of cost of atrial fibrillation is required.

Further, Howard, Gazmararian and Parker (2005) examined the effects of low medical literacy on use and costs of clinical care. Samples of the paper were consisted of 3260 non-institutionalized aged persons who enrol in a Medicare directed care scheme. The study used a 2-part regression model and the findings revealed that after contrasted to those having sufficient medical literacy, disaster room costs were considerably higher among

those had insufficient medical literacy, whereas disparities in total and in-patient costs were slightly considerable. The total costs were higher in the secondary medical literacy set, but the disparity was not considerable. The paper concluded that people with insufficient medical literacy usually incur higher health costs and employ an inefficient service mix.

Mosquera *et al.* (2014) explored the challenges to the implementations of primary healthcare tactic in a market oriented context healthcare scheme in Bogota-Colombia. The paper employed a qualitative multiple study case method and eighteen semi-structured interviews with key informants and fourteen FGDs. The study found that the key hinderers constituted advance of the state policies and a medical system based on neo-liberal ideology, the need of a steady financing source, the perplexing and inflexible policies as well as the high labour turnover. The study also found that the need of capabilities among medical employees in regard of family unit focus and social direction, and the partial participation of firms outside the medical division in the generation of inter-sectoral reply and promotion social involvement.

2.4 Research Gaps

A number of studies were reviewed among them Hattingh (2015) studied the moral challenges in managed care while Simon, *et al* (1999) assessed the views of MHC among residents, students faculty as well as deans at the health schools in U.S. but the studies did not explicitly establish whether attitude was a challenges of MHC implementation. In Kenya, Smith and Broek (2017) also examine the performance of the free maternity services policy and its effects for medical system regulation but the study focused on free maternity and not MHC. Kgasi (2010) studied the position of a director in a directed care organization and established that managers knew their roles with regards to MHC but the study did not seek the views of medical workers.

Further, Baker *et al* (2002) examined the functional medical literacy and the risk of hospital admission among Medicare directed care enrolees while Kimama (2011) also assessed the difficulties faced in the performance of HMIS in Nairobi based hospitals but the focus was implementation of information systems. Kim *et al* (2009) examined the costs of atrial fibrillation in U.S directed care firms while Howard, Gazmararian and Parker (2005)

examined the effect of low medical literacy on health care use and expenditures but the studies focus was on the –amount of costs incurred and did not indicate whether costs influenced MHC implementation. Thus, despite the fact the reviewed studies discuss the various concepts of the study, the studies have now exclusively covered the challenges which affect the implementation of MHC among private sector healthcare providers.

2.5 Conceptual Framework

The aim of a conceptual framework is to diagrammatically depict the relationship between the research variables. The conceptual framework for this study is made up of MHC implementation as the dependent variable while the independent variables comprise of health workers’ attitude, health workers’ knowledge and costs of MHC. The conceptual structure for this study is summarized in Figure 2.1.

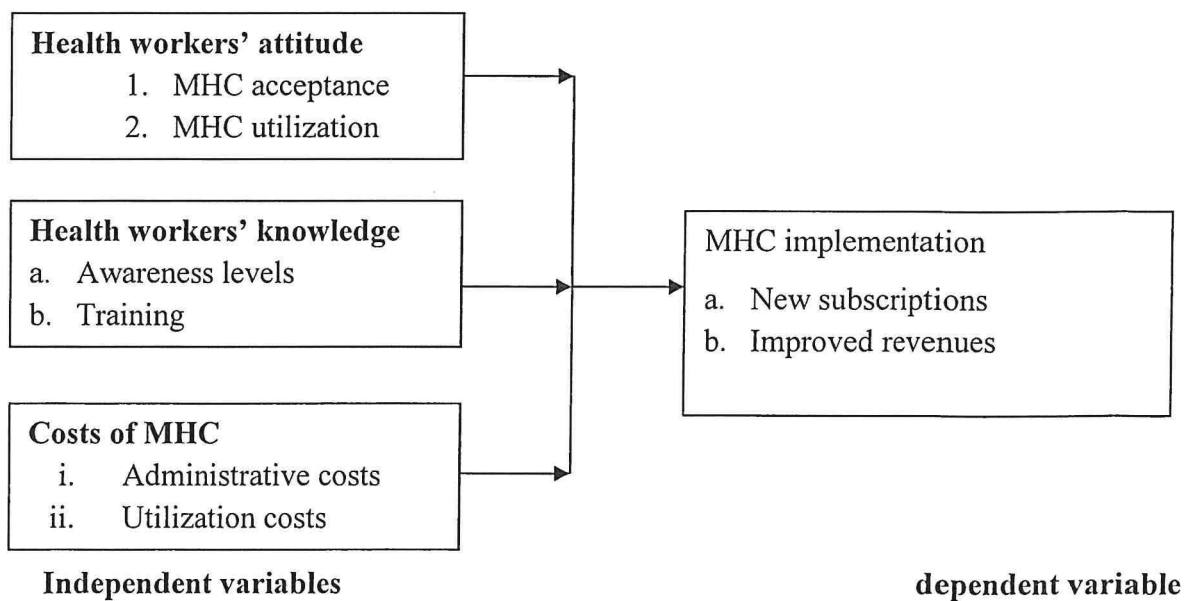


Figure 2.1 Conceptual Framework

Source: Researcher (2019)

2.7.1 Operationalization of Variables

The study considered health workers’ attitude towards MHC whose indicators acceptance and utilization of MHC by medical workers and health workers knowledge on MHC whose indicators were awareness levels and training on MHC and the costs of MHC whose indicators include administrative and utilization costs as the independent variables. The

study also incorporated MHC by new subscriptions and enhanced revenues as indicators of the dependent variable, though there is limited literature on the same owing to its sensitive nature most organisations are not willing to revile this information. Emphasis of the study will therefore be on the independent variables and the perception on new subscriptions the variables are operationalized as shown in Table 2.1.

Table 2.1 Operationalization of Variables

Variable	Measurement	Scale	Analysis
MHC implementation	New subscriptions Improved revenues	5 point Likert scale	Descriptive Inferential
Health workers' attitude	Acceptance of MHC Utilization of MHC	5 point Likert scale	Descriptive Inferential
Health workers' knowledge	Awareness levels Training on MHC	5 point Likert scale	Descriptive Inferential
Costs of MHC	Administrative costs Utilization costs	5 point Likert scale	Descriptive Inferential

2.6 Chapter Summary

The chapter explores the Kutzin descriptive framework (2001) the framework sites 4 main arms in healthcare financing: collection of revenues, resource pooling, procuring and service provision. The chapter also looks into the indemnity model which explains how insurance indemnifies the receiver from funding expenditures linked with healthcare. The chapter reviewed studies on health workers attitude towards, health worker knowledge on MHC and the cost of MHC. The research also presented a conceptual model, operationalized the study variables and identified gaps from the reviewed studies.



CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

The research methodology section contains the study design, the target population and sampling technique, the procedure for collection of data, validity and reliability. The chapter also presents the data analysis techniques and the study's social considerations.

3.2 Research Design

To establish the challenges facing implementation of MHC in private hospitals in Kenya this study adopted a cross sectional descriptive study. A cross-sectional descriptive design was used as it entails the recognition of an incident of attention and of the variables within the incident, improvement of theoretical and functioning explanations of the variables, and depiction of variables (Saunders *et al.*, 2007).

3.3 Population and Sampling

The population of this research was made of the 9 Avenue Healthcare Centres in Nairobi County and the unit of analysis was the 104 medical workers in these centres, this because they are key in providing important information on MHC. The study was therefore a census of the 9 healthcare centres and the 104 medical workers

A census was undertaken since the population was small and finite. In a census, data from all the elements of the population were included in the study hence sampling was not undertaken (Kothari, 2008). Table 3.1 shows the study population

Table 3.1: Population and Sample

Category	Total	Sample	Percent
Medical doctors	13	13	12.5
Dental offices	9	9	8.7
Patient Attendants	26	26	25.0
Nurses	39	39	37.5
Other technicians	17	17	16.3
Total	104	104	100.0

Population sampling table research on challenges on MHC Implementation in Kenya 2019

3.4 Data Collection

This research made use of primary data, which were gathered using a self-administered questionnaire, which was presented to the willing participants. A questionnaire was used since obtained it helped to obtain large amounts of data from a great number of individuals within a short span of time and in a moderately cost effectual manner. The questionnaire contained structured questions which were based on Likert range of 1 to 5 and contained two sections where the first section obtained data on respondents' demographic information and the subsequent part obtained data on the study variables.

3.5 Validity and Reliability

The extent to which findings obtained from the scrutiny of data actually represents the incident under research is referred to as validity. To ensure validity of the research questionnaires expert opinion from the project supervisor and other departmental lecturers was sought. Additionally, a pilot study was carried out and the instrument was pretested to various health workers of one of the healthcare outpatient set up. This helped identify and change any ambiguous questions and help to eliminate author bias.

To assess the reliability of the research questionnaire, the study used the Cronbach alpha coefficient. Table 3.1 show the reliability analysis results

Table 3.1: Reliability Statistics

Variable	Cronbach's Alpha	N of Items
Health workers attitude	.724	6
Health workers knowledge	.770	5
Costs of MHC	.822	4
MHC implementation	.807	7
Overall	.793	22

The Cronbach results on table 3.1 shows that all the Cronbach alpha coefficients of 0.724, 0.770 and 0.807 are more than the recommended threshold of 0.7. This indicates that the instrument is reliable for the study.

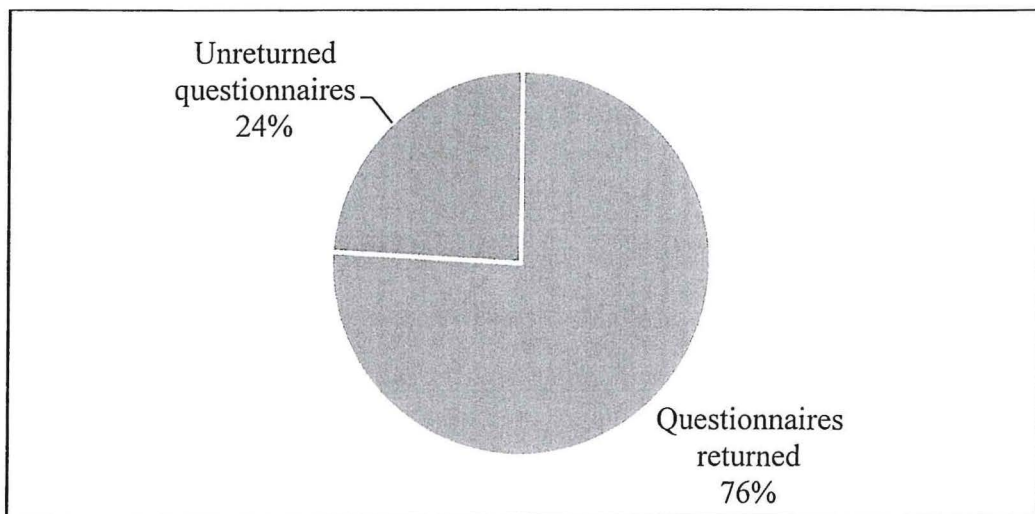
3.6 Data Analysis

This chapter shows the results of the analysed data. The chapter presents the response rate results, the reliability statistics results and the respondents' demographic characteristics. The chapter also presents the results of the study variables which include health workers attitude, health workers knowledge, costs of managed health care programs and MHC implementation. Further, the chapter presents findings of regression analysis, which comprises the model summary, analysis of variance and summary of the coefficients.

3.6.1 Response Rate

This study carried out a census of the 104 medical workers in the 9 Avenue Healthcare Centres in Nairobi County. The study however managed to obtain complete data from 79 medical workers leading to response rate of 76%, which was considered sufficient for the study. According to Mugenda and Mugenda (2006), response rate of above 70% is deemed appropriate. Figure 3.1 shows the results

Figure 3.1: Response Rate



Response rate chart for research on challenges on MHC Implementation in Kenya 2019

To assess the reliability of the research questionnaire, the study used the Cronbach alpha coefficient. Table 4.1 show the reliability analysis results

Table 4.1: Reliability Statistics

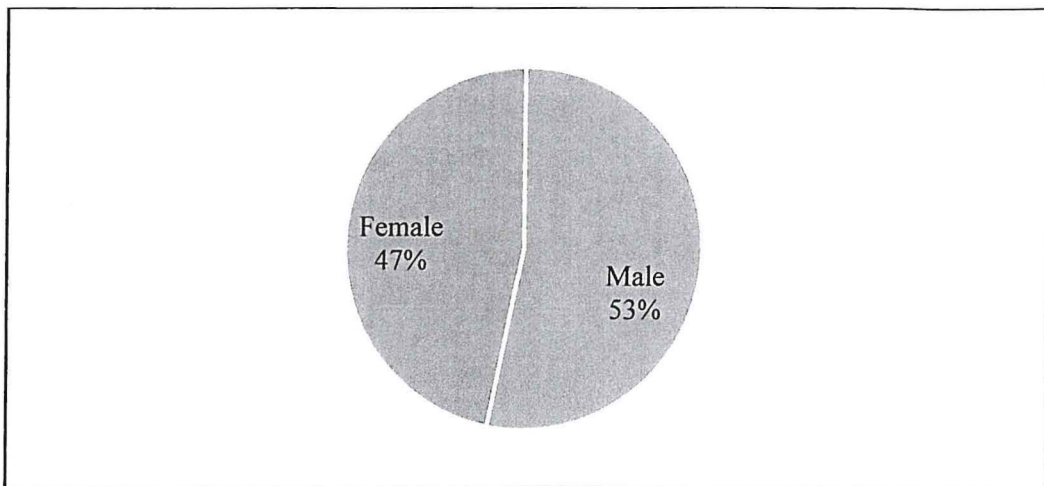
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Overall	.793	22

The Cronbach results on table 4.1 shows that all the Cronbach alpha coefficients of 0.724, 0.770 and 0.807 are more than the recommended threshold of 0.7. This indicates that the instrument is reliable for the study.

3.6.2 General Information

This section provides the results of the respondents gender, the period worked and the respondents education levels. The results are as follows

Figure 3.2: Gender of the Respondents



The results on figure 3.2 show the gender of the respondents. The results show that 53% of the medical workers were of the male gender while on the other hand 47% of the medical workers were of the female gender. The results indicate that majority of the medical workers were male even though the percentage of female medical workers were high.

Period Worked as a Medical Worker

Table 3.2: Period Worked as a Medical Worker

Period	Frequency	Percent
Less than 2 years	16	20.3
3 – 4 years	38	48.1
Over 5 years	25	31.6
Total	79	100.0

Table depicting Period Worked: research on challenges on MHC Implementation in Kenya 2019

The results of the period worked by the respondents on table 3.2 shows that 20.3% of the respondents had worked as medical workers for less than two years while 48.1% had worked for a period of 3 – 4 years. On the other hand, 31.6% of the respondents had been medical workers for period of more than 5 years. The results on average show that majority of the respondents had been medical workers for more than 2 years hence they had knowledge on managed health care.

Education Levels

Figure 3.3: Education Levels chart for research on challenges faced during the implementation of MHC in Kenya research 2019

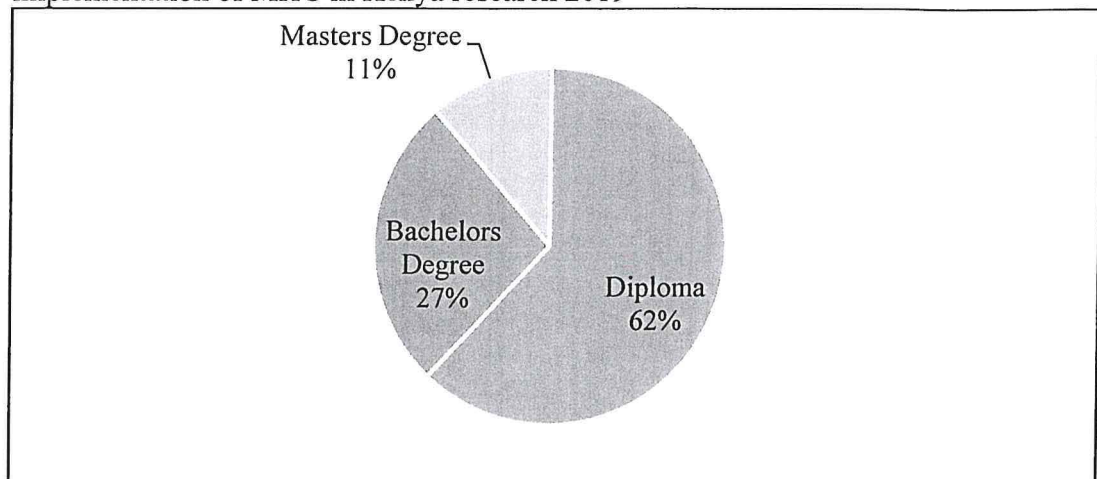


Figure 3.3 indicates that 62% of the respondents were diploma holders and mostly comprised of nurses, patient attendants, public health officers, pharmaceutical officers, laboratory technicians, therapists and counsellors while 27% were bachelor degree holders and comprised of medical doctors, dental officers graduate nurses and pharmacists. On the other hand, 11% of medical workers were master's degree holders. The results indicate that the respondents had respective educational qualification in various fields.

3.6.3 Challenges

This section show the results of the study variable which include health workers' attitude, health workers knowledge and costs of MHC. The results were as follows.

Health Workers' Attitude

Table 3.3: Health Workers' Attitude

Statement	Mean	Std. Deviation
Health workers' perception greatly affects the implementation of the healthcare financing strategy	4.53	.502
For MHC to succeed in implementing there must be deep commitment and support by health workers	4.47	.502
Fee -for-service treatment is better than managed care in terms of access in private hospitals	3.03	.832
MHC enhances the quality of the doctor-patient relationship in private hospitals	4.08	.730
Healthcare professionals working in managed care are particularly exposed to conflicts and misaligned incentives	2.46	.971
Negative views of managed care are widespread among health workers in private hospitals in Kenya	2.25	.884

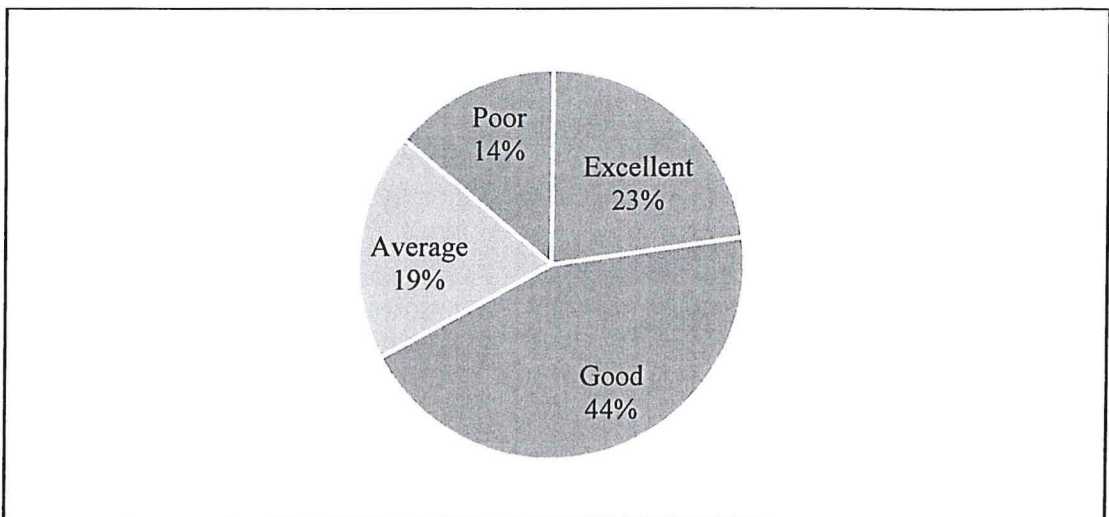
Table 3.3 shows that the respondents agreed that health workers' perception greatly affects the implementation of the healthcare financing strategy as indicated by the mean value of 4.53 which corresponds to the likert scale value of 4 which stands for agree. The respondents also agreed that for MHC to succeed in implementing there must be deep

commitment and support by health workers and that MHC enhances the quality of the doctor–patient relationship in private hospitals as indicated by mean values of 4.47 and 4.08 respectively. The respondents were however neutral on whether the fee-for-service treatment was better than managed care in terms of access in private hospitals as indicated by mean value of 3.03. In addition, the results show that the respondents disagreed that healthcare professionals working in managed care are particularly exposed to conflicts and misaligned incentives and that negative views of managed care are widespread among health workers in private hospitals in Kenya as indicated by mean values of 2.46 and 2.25 respectively.

Health Workers Knowledge

This section first assessed understanding of MHC programs adopted by the hospital’s medical workers as indicated in figure 3.4 and also evaluated various statements on health workers knowledge towards managed health care as indicated under table 3.4.

Figure 3.4: Knowledge on MHC Programs chart for research on challenges on MHC Implementation in Kenya 2019



The results on figure 3.4 shows that 44% of the respondents indicated that the hospital medical worker knowledge on MHC programs was good while 23% indicate that it was excellent. The finding also show that 19% and 14% of the respondents indicated that the

hospital medical workers knowledge on MHC programs was average and excellent respectively. The results on average indicate that most of the medical workers at the hospital had good knowledge on MHC programs.

Table 3.4: Influence of Health Workers Knowledge

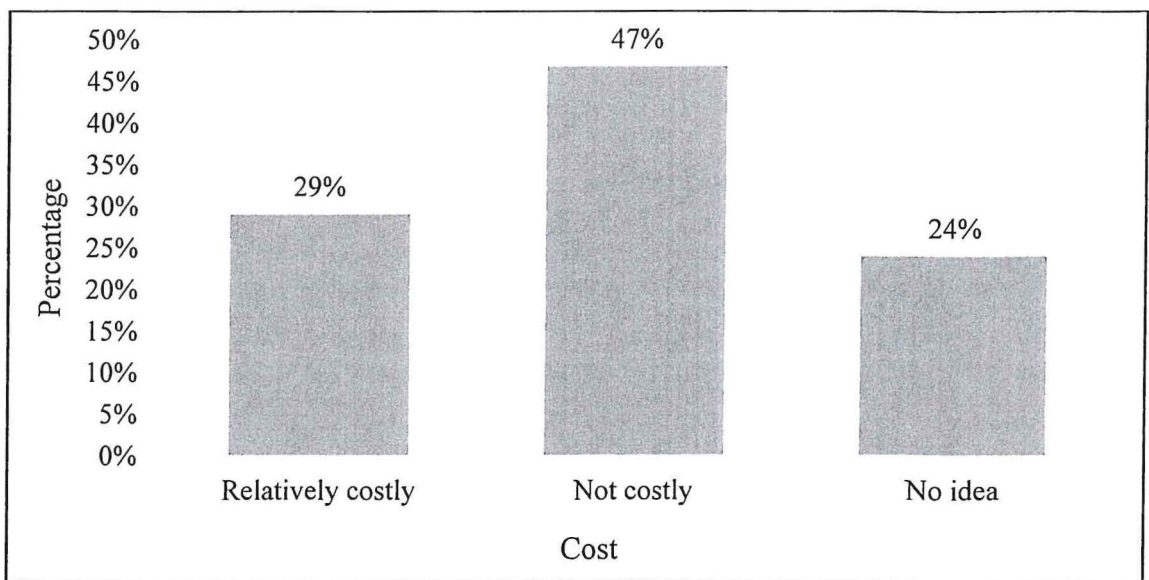
Statement	Mean	Std. Deviation
Lack of health workers knowledge is great a barrier towards implementation of MHC programs	4.58	4.595
There is limited knowledge by health workers about healthcare financing strategies among private hospitals	2.61	.975
For managed care to be successful, the education of health workers is necessary	4.41	.494
Private hospitals intending to implement MHC must train their staff on managed care principles	4.42	.496

The results on table 3.4 shows that the respondents agreed that lack of health workers knowledge is great a barrier towards implementation of MHC programs as indicated by the mean value of 4.58 which corresponds to the scale value of 4 which stands for agree. The results however shows that the respondents disagree that there was limited knowledge by health workers about healthcare financing strategies among private hospitals as indicated by mean value of 2.61 which corresponds to the scale value of 2 which stands for disagree. The results further show that the respondents agreed that for managed care to be successful, the education of health workers was necessary and that private hospitals intending to implement MHC must train their staff on managed care principles as indicated by mean values of 4.41 and 4.42 respectively.

Costs of MHC

This section sought to assess the perceived cost of implementation of MHC programs under figure 3.5 and also evaluated the major types of costs associated with MHC programs under table 3.5. Further, the section presents the results of the range of MHC program costs under table 3.6 and finally the results on how costs of MHC programs affect productivity in figure 3.6.

Figure 3.5: Cost of MHC Programs



For research on challenges on MHC Implementation in Kenya 2019

The findings on figure 3.5 shows that 47% of respondents MHC programs were not costly while 29% of indicated that the MHC programs were relatively costly whereas 24% of the respondents did not have an idea on how costly the MHC programs were.

Table 3.5: Costs Associated With MHC Programs

Costs	Frequency	Percent
Set up costs	10	12.7

Administrative costs	32	40.5
Operational costs	17	21.5
Others	20	25.3
Total	79	100.0

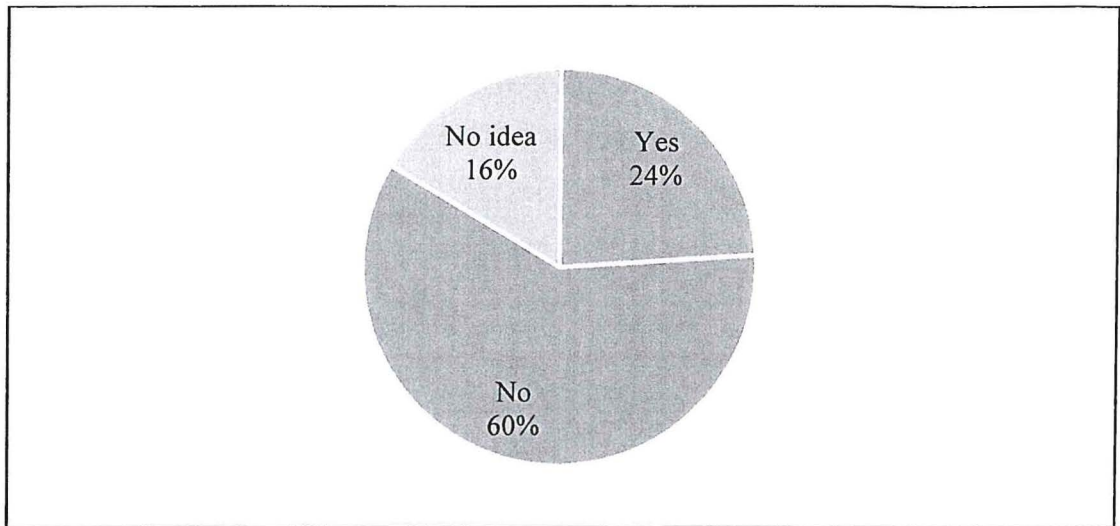
Table 3.5 shows that 40.5% of the respondents indicated that administrative costs was the major costs associated with MNC programs while 21.5% cited operational costs as one of the costs. On the other hand, 12.7% cited set up costs whereas 25.3% indicated other costs among them marketing costs, training and development programs respectively. This indicates that a number of costs are associated with MHC programs with the major administrative costs being the major one.

Table 3.6: Range of MHC Program Costs

	Frequency	Percent
Less than 10million	37	46.8
11million – 50 Million	16	20.3
No idea	26	32.9
Total	79	100.0

Table 3.6 shows that 46.8% of the respondents said that the range of cost of implementing MHC programs was less than 10 million while 20.3% of the respondents indicated that the costs ranged between 11 and 50 million. On the other hand, 32.9% of the respondents had no idea of the costs incurred by the hospital during MHC programs implementation.

Figure 3.6 Costs of MHC Programs and Productivity for research on challenges on MHC Implementation in Kenya 2019



The findings on figure 3.6 shows that 60% of the respondents indicated that the costs associated with MHC programs did not affect the productivity of private hospitals while 24% agreed that the cost associated with MHC programs affect private hospitals productivity. The results further show that 16% of the respondents did not have an idea of whether cost associated with MHC programs affected private hospital productivity.

3.6.4 MHC Implementation

Table 3.7: Status of MHC Implementation

Statement	Mean	Std. Deviation
New subscriptions	2.59	.689
Improved revenues	2.34	.918
Enhanced quality of services	2.70	.774
Increase in number of clients	2.56	.712
Reduced labour and staff conflicts	2.01	.79 2
Improved response to emergencies	2.96	.741
Reduction of hospital bills	2.29	.870

The results on table 3.7 shows that due to implementation of managed health care programs new subscriptions, revenues, number of clients and quality of services and had improved to a large extent as shown by the mean values of 2.59, 2.34, 2.56 and 2.70 respectively which corresponds to the scale value of 2 which stands for large extent. The results also

show that labour and staff conflicts had reduced to a large extent as indicated by the mean value of 2.01 whereas response to emergencies had improved to a large extent as shown by mean of 2.96 while hospital bills had also reduced to a large extent as indicated by a mean value of 2.29 respectively.

3.6.5 Regression Analysis

The study adopted the multiple linear regression method to establish the connection among the dependent variable and the independent variables. The regression model comprises of the model summary results shown by table 3.8, analysis of variance (ANOVA) shown by table 3.9 and regression coefficients results under table 3.10.

Table 3.8: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.537 ^a	.288	.259	2.63298

a. Predictors: (Constant), Costs of MHC, Health workers' attitude, Health workers knowledge
 The findings on table 3.8 shows that the coefficient of determination (R square) is 0.288 which shows that 28.8% of the variation in the dependent variable (MHC implementation) is explained by the independent variables which comprise of costs of MHC, health workers' attitude, health workers knowledge. The R square value (correlation coefficient) of 0.537 shows that there is a strong correlation between the dependent and independent variables.

Table 3.9: ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	210.173	3	70.058	10.106	.000 ^b
	Residual	519.942	75	6.933		
	Total	730.115	78			

a. Dependent Variable: MHC implementation
 b. Predictors: (Constant), Costs of MHC, Health workers' attitude, Health workers knowledge
 The ANOVA results on table 3.9 indicates that the F statistics value of 10.106 is statistically significant at 95% confidence level as indicated by the p value ($0.000 < 0.05$). This indicates that the regression model is fit and significant to assess the relationship between the research variables.

Table 3.10: Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	7.290	.667		10.927	.000
1 Health workers' attitude	.061	.028	.215	2.178	.033
Health workers knowledge	.381	.103	.375	3.707	.000
Costs of MHC	.328	.081	.414	4.073	.000

a. Dependent Variable: MHC implementation

The coefficient results on table 3.10 shows that the relationship health workers' attitude and implementation of MHC programs was positive (B=0.061) and statistically significant as indicated by p value ($0.033 < 0.005$). The results also show that there was a positive (B=0.381) and statistically significant (P value = $0.000 < 0.05$) relationship between health workers knowledge and MHC implementation. Finally, the results show that there is a positive (B=0.328) statistically significant (P value = $0.000 < 0.05$) relationship between MHC costs and implementation of MHC programs.

3.7 Ethical Considerations

To ensure conformance with ethical considerations, informed consent was sought from the respondents and the purpose of the study was described. In addition, the respondents were made aware that participation was voluntary and they had the consent to withdrawal from the research at any point. Additionally, the respondents' identity remained anonymous and the provided information was classified as secret and was not be disclosed without the approval of the respondents. Additionally, the collected data was only used for academic purposes only.

CHAPTER FOUR: DISCUSSION

4.1 Health Workers Attitude and the Implementation of MHC

The study found that health workers' perception greatly affects the implementation of the healthcare financing strategy and that for MHC to succeed in implementing there must be profound commitment and support by health workers. These findings are supported by Dymowski, (2010)

The study further revealed that MHC enhances the quality of the doctor-patient relationship in private hospitals. Further, the study found that healthcare professionals working in managed care were not exposed to conflicts and misaligned incentives and that negative views of managed care were not widespread among health workers in private hospitals in Kenya. Simon, et al (1999) revealed that the respondents indicate that the fee for service was better rated than managed care in stipulations of access, lessening the moral conflicts and the superiority of the doctor-patient association.

The regression results revealed that a positive attitude by medical workers leads to the adoption and implementation of MHC programs. In support of the findings, Nzioki, Onyango and Ombaka (2015) revealed that the factors affecting the efficiency of CHS in the provision of MCH services included health workers attitude, challenges that face social medical staff, social-cultural factors as well as economic factors and lack of motivation among community medical workers. Simon, et al (1999) concluded that negative attitude of managed care was extensive among the residents, medical students, and deans of medical school. , Pyone, Smith and Broek (2017) found that health worker attitude on new policies, weak enforcement mechanisms and misaligned incentives led to weak policy performance of health care policies in Kenya

4.2 Health Workers Knowledge and Implementation MHC

The study results revealed that most of the medical workers had good knowledge on MHC programs and that lack of health workers knowledge was a great barrier towards implementation of MHC programs. In addition the findings show that for managed care to

be successful, education of health workers was necessary and that private hospitals intending to implement MHC must train their staff on managed care principles. In similarity, Dymowski (2010) supports that for the managed care plans to thrive health workers education was pivotal. Baker et al (2002) concluded that insufficient literacy was an independent factor of risk for hospital admission among elderly managed care enrollees

The regression results revealed that there was a positive and statistically significant relationship between health workers knowledge and MHC implementation hence an indication that an increase in knowledge on MHC programs enhance the adoption and implementation of MHC programs. In similarity, Kimathi (2017) found that limited knowledge by health workers about healthcare financing strategies, is detrimental to achieving the desired impact and the realization of the highest possible standards of health for all. Wolf, Gazmararian and Baker (2005) also found that individuals with inadequate health literacy were more likely to report difficulties with instrumental activities of daily living.

4.3 Costs of MHC and the Implementation of MHC

The results found that MHC programs were not costly and that administrative costs was the major costs associated with MHC programs among others which included operational costs, set up costs, marketing costs, training and development programs respectively. Maynard and Bloor (1998) observed that MHC involvements may lead in raised costs of medical plans, if the managerial costs on the implementation MHC do not lead in matching expenditure benefits, through additional of care effectual provisions. The findings also revealed that the costs associated with MHC programs did not affect the productivity of private hospitals, and that high costs would positively affect implementation of MHC programs. A study by Howard, Gazmararian and Parker (2005) revealed that health care costs were considerably higher among those had insufficient medical literacy.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusions

The study based on the finding concludes that health workers attitude positively and significantly affects the implementation of MHC among private hospitals in Kenya and positive attitude by medical workers leads to the adoption and implementation of MHC programs.

Secondly, the study established that health workers knowledge significantly and positively affects the implementation of MHC in private hospitals in Kenya. Finally, the study found that high costs of managed programs would positively affect implementation.

5.2 Recommendations

The study based on the conclusion that a positive attitude by medical workers leads to smooth implementation of MHC programs, the study recommends that the management of private hospitals in Kenya should involve medical workers in planning and implementation of MHC programs.

Further, health workers knowledge significantly and positively affects the implementation of MHC in private hospitals in Kenya hence the study recommends that the management of private hospital in Kenya should develop training and development programs and ensure training is carried out frequently on any new managed health care program by the hospitals. Training and development programs would ensure that medical workers enhance their knowledge and acquaint themselves with appropriate skills which would ensure the success of the managed health care programs.

Finally, the study recommends that the management of private hospitals should carry out due diligence and adequate research before implementing or instituting any MHC program in order to ascertain the cost implications.

5.3 Study Limitations

The scope of this study was private hospitals in Kenya and data was collected from the Avenue healthcare group in Nairobi hence the findings may not be generalised to public

hospitals or other hospitals in Kenya which use difference healthcare financing models. Further, the study relied on primary data which was collected using questionnaires and a 100% response rate was not achieved. In addition, during the course of the research a number of hindrances among lack of cooperation and absenteeism by some of the respondents due work shifts. However, to ensure fully cooperation the research explained the purpose of the study to the respondents and also liaised with the hospitals management for the appropriate time to carry out the research. This research also collected the views of the medical workers and did not involve the hospital clients who use the MHC services. Finally, the research findings were carried out in Kenya a developing country where MHC usage and implementation is at infancy hence the findings may not be generalizable to other developed countries.

In addition there was limited literature on managed healthcare new subscriptions, and revenue statement from MHC institutions based on the sensitivity of the data.

5.5 Areas for Further Research

The model summary of the study indicated that 28.8% of the variation in the dependent variable (MHC implementation) was accounted for by the independent variables (costs of MHC, health workers' attitude and health workers knowledge) hence 71.2% of the variation was accounted for by other factors. The study therefore recommend a similar study which would consider other variables. In addition, a similar research can be carried out where the views of patients and clients who use the MHC program is taken to find out the various challenges that are associated with the use of the MHC programs.

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APPENDICES

Appendix I: Introduction Letter

Margaret Mbugua

Strathmore University

P. O. Box 59857-00200,

Nairobi

Dear Respondent,

RE: REQUEST FOR RESEARCH PARTICIPATION

I am a student at Strathmore University carrying pursuing a Master of Business Administration Degree. I am currently undertaking a research on the challenges facing the implementation of MHC in private hospitals in Kenya with focus on Avenue Healthcare Group. The research is academic in nature and aimed at fulfilling the requirements for award of a degree. Therefore, I kindly request to voluntarily participate in the research by filling out the attached questionnaire. The information provided will be kept confidential and will only be used for the intended purpose. Your cooperative and support will be highly appreciated

Thank you in advance.

Yours faithfully

Margaret Mbugua

Mobile: 0725600575

Appendix II: Questionnaire

Instructions

1. Please do not write your name and contacts
2. Tick or fill where appropriate
3. Kindly read and understand the questions before responding

Section I: Background information

1. Indicate your gender

Male

Female

2. Indicate the number of years you have been a health worker

Less than 2 years

3 – 4 years

Over 5 years

3. Indicate your highest level of education

Diploma

Bachelors Degree

Masters Degree

Others (specify) _____

Section II: Challenges

Part A: Health Workers Attitude

4. State the extent into which you agree or disagree with the following statements on health workers attitude towards managed health care. Use the following scale as appropriate

1-Strongly disagree, 2-Disagree, 3-Neutral, 4-Agree and 5-Strongly agree

Statement	1	2	3	4	5
a. Health workers' perception greatly affects the implementation of the healthcare financing strategy					
b. For MHC to succeed in implementing there must be deep commitment and support by health workers					
c. The fee-for-service treatment is better than managed care in terms of access in private hospitals					
d. MHC enhances the quality of the doctor-patient relationship in private hospitals					
e. Healthcare professionals working in managed care are particularly exposed to conflicts and misaligned incentives					
f. Negative views of managed care are widespread among health workers in private hospitals in Kenya					

Part B: Health Workers Knowledge on MHC

5. How you rate your understanding of MHC programs adopted by your organization

Excellent [] Good [] Average [] Poor []

6. State the extent into which you agree or disagree with the following statements on health workers knowledge towards managed health care. Use the following scale as appropriate

1-Strongly disagree, 2-Disagree, 3-Neutral, 4-Agree and 5-Strongly agree

Statement	1	2	3	4	5
a. Lack of health workers knowledge is great a barrier toward implementation of MHC programs					
b. There is limited knowledge by health workers about healthcare financing strategies among private hospitals					

Statement	1	2	3	4	5
c. For managed care to be successful, the education of health workers is necessary					
d. Private hospitals intending to implement MHC must train their staff on managed care principles					

Part C: Costs of MHC

7. How costly would you rate the costs associated with the implementation of MHC programs

Very costly [] Relatively costly [] Not costly [] No idea []

8. Indicate the major costs associated with managed health care programs

Set up costs [] Administrative costs [] Operational costs []

Others(specify)

9. Indicate the range of costs incurred by your hospital during the implementation and set up of MNC programs

Less than 10million [] 11million – 50 Million [] Above 50 Million []

10. Does costs of implementing and running of MHC programs affect the productivity of private hospitals

Yes [] No [] No idea []

Part D: MHC Implementation

11. Please indicate the extent into which the listed areas have grown due to managed care health care programs implementation by your organization. Use the following scale where appropriate

1- Very large extent, 2 –Large Extent 3 – Moderate extent 4 - Minimal extent 5- Not at all

	1	2	3	4	5
a. New subscriptions					
b. Improved revenues					
c. Enhanced quality of services					
d. Increase in number of clients					
e. Reduced labour and staff conflicts					
f. Quick response to emergencies					
g. Reduction of hospital bills					

12. Apart from the health workers attitude, health workers knowledge and cost of managed health care, list other factors that affect the implementation of MHC by private healthcare facilities in Kenya

Thank you for your time

